THE AGING IMPACT STUDY

February, 1990

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EXECUTIVE SUMMARY

Cognizant of Statistics Canada's population projections, Executive Council has determined that the impact of an aging population on government programming as identified by the Department of Health & Social Services Strategic Overview 1987, warranted an examination. Subsequently, the Department of Health and Social Services was directed to study this impact in respect to Government Manors, Hospital Services, Private Nursing Homes, Community Care Facilities, Home Care and Support Programs, and other options for community living. This report presents the findings and views of the ad hoc Committee established for that purpose.

The Committee approached its task by addressing current programs and issues within the province relating to the senior population. Prior national and provincial reports were discussed. A segment of the Committee's work also involved the review of 18 submissions from professional associations and Island organizations regarding issues specific to an aging population. For a specific listing of submissions see Appendix A.

All sectors represented on the Aging Impact Study Committee have identified a need for on-going service and system planning and coordination, yet there is no formal process in place to meet this need. The Aging Impact Study Committee recommends a mechanism for system planning and coordination be established and involve senior representatives of the many various sub-systems delivering health and social services. This must occur before the addition of any new services, since the mere addition of services does not improve quality of care delivered to the elderly. The theme of a coordinated approach to service delivery emerged as a strong issue within the Mental Health Review (June 1988). A similar conclusion was also reached by the individuals participating in the Health Care Forum (February, 1988).

The need for a multisectoral approach to planning and coordination of health and social service for the elderly arises from the structures of the informal and formal care systems in which there are many players but no single authority, and the necessary interfacing that must occur with the authority responsible for providing such options as housing.

The Committee is of the belief that there is a significantly strong network of informal community support services that provide approximately 80% of care to the elderly. Clearly, the recommendations relating to the support of the informal care sector are of utmost priority.

The Committee recommends the adoption of the goal of achieving a better balance among health promotion and prevention. When necessary treatment within the formal care system is indicated, a rehabilitative approach to the care of the elderly is in order. The re-orientation toward this approach necessitates a number of additional recommendations on philosophical, structural, and process changes within the formal care system.

Other recommendations indicate a need to address recurring pressure points in regard to demand for expansion of nursing care beds. Creative options for expansion of this sector may also need to be entertained in light of most efficient use of scarce resources.

The housing of an elderly population also is of pivotal importance. The majority of elderly persons do wish to stay in independent living situations. A coordinated effort is needed to accomplish this.

The Aging Impact Study Committee believes the challenge of an aging population enforces now, more than ever, the common concern and common philosophical ground among health and social service providers to deliver services that facilitate empowerment of individuals and communities to assume more responsibility for their own needs.

With Government helping to create an environment for multi-sectoral planning, the health and social needs of an aging population can be more effectively addressed and the fear of undue strain on the system can be averted.

1. INTRODUCTION

1.1 Historical Perspective

Services to meet the needs of seniors on Prince Edward Island have a lengthy history. The last major study, "Towards Meeting the Needs of Senior Citizens in Prince Edward Island," was completed in 1981. This three-year research project was made possible through funding from the Welfare Grants Division of the Department of National Health and Welfare. One of the major policy recommendations was that the Social Services Branch encourage other providers of service to develop, in conjunction with Social Services or alone, services which enable senior citizens to remain in their own homes. The present day evolution of the Division of Home Care and Supports reflects this policy direction.

Since 1981, the majority of services directed toward seniors, with the exception of medical care and housing, have been delivered under the one administrative structure of the Department of Health and Social Services. This Department is responsible for the funding, regulation and operation of long-term institutional, community based services and other programs that involve services to seniors. To meet the needs of an aging population within the next decade and beyond, the Department of Health and Social Services must develop a philosophy to guide program direction for services to the elderly. An all encompassing philosophy must acknowledge the rights of seniors to be individuals responsible for their own lives, involved in a lifestyle of their choice and partners in the decision making process for health and social planning.

Within the last decade the government of Prince Edward Island has recognized the growing number of seniors within its boundaries. The needs of seniors have been comprehensively addressed through the: (1) establishment of a Home Care and Support Program; (2) provision of increased funding to convert existing beds in homes and manors to provide for heavier levels of care; (3) licensing of Community Care facilities; (4) expansion of the Seniors Citizens Housing Program in terms of housing units and various grants for upgrading private dwellings; and (5) introduction of the Drug Cost Assistance Program.

The next decade may prove to be another period in which the Government of P.E.I. will be challenged to meet the demands of an aging population. Will there really be a crisis or with careful planning and a coordinated policy effort can we meet the challenge?

1.2 The Aging Impact Study 1989-1990

In its 1987 Strategic Policy Overview, the Department of Health and Social Services indicated that Prince Edward Island already had a ratio of seniors (12.7%) - a level predicted for the year 2000 for the country as a whole (Source: Statistics Canada). On a positive note, this also affords the province the opportunity to serve as a model for the rest of the country as it strives to respond to the many implications of an aging population.

Following a review of the Health and Social Services Strategic Policy Overview, Executive Council directed the Department to undertake a major policy review and to include:

"projection of numbers requiring services, projection of levels of care required; including hospitals, role of the private sector, role of Government, and regulations and control of care."

1.3 Committee Composition

In March of 1989, the composition of an Aging Impact Study Committee was finalized. The Committee was chaired by the chairman of the Community Care Facilities and Nursing Homes Board. Initially, the Committee included a representative from the Division of Aging and Extended Care and the Division of Home Care and Support, the Hospital and Health Services Commission, the P.E.I. Hospital Association, and the P.E.I. Medical Society. Two later appointments to the committee included representatives from the P.E.I. Housing Corporation and the P.E.I. Seniors Federation.

1.4 Terms of Reference

From the outset it was apparent that the scope of the Committee's work necessitated an in-depth review of the many issues outlined in the Executive Council memo. The general terms of reference for the study stated that the Committee was to study the impact that an aging population will have on government programming throughout the next decade with particular focus on the following areas: Government Manors; Private Nursing Homes - profit and non-profit; Community Care Facilities; Hospitals - present services and the need for geriatric assessment units; Home Care and Support Programs; and new options for community living.

1.5 Process

The Committee began its work in mid April 1989 and continued with monthly meetings until August 1989. Meetings were held at one to two week intervals from September to February 1990. The Committee assessed the evolution of services for the elderly, recognizing that a variety of services occur in an array of public and private settings. The Committee attempted to determine the adequacy of the present level of services. To accomplish this task the Committee examined relevant national reports. All Committee members gave their respective constituency perspective on the impact of an aging population. A projection of the population for the next decade was also a factor in the discussion process. To broaden the richness of the data for the study report, 18 submissions from government agencies, professional associations and other interested consumer groups (see complete list in Appendix A) were discussed and analyzed. Having exhausted discussion on all of the topics, the Committee proceeded to the report recommendation phase and completed this task through a process of committee consensus.

2. POPULATION AGING AND ISSUES

The phenomenon of an aging population is receiving great attention of late by individuals within Canada and in other industrialized societies. This demographic trend of a greater proportion of elderly will continue and eventually peak when the Baby Boom Generation reaches old age.

2.1 Who are the Aging?

Aging is often viewed as a process that begins in later life, usually around age 65 years. The usual exit from the paid labor force at this age has highlighted 65 as a chronological marker of when one becomes a senior. Individuals who have passed that age are often regarded as passive and dependent members of society. This misconception must be dispelled. Considerable diversity exists among the population designated as seniors or aged. Different subgroups of the senior population have different needs. A senior age need not be equated with ill health and chronic disease that leads to total dependence on others and ultimate admission to long-term care institutionalization. In fact on Prince Edward Island approximately only 6.2% of seniors are residing in public and private nursing care institutions. The Division of Home Care and Support provides services to 7% of seniors. The remaining percentage of care provided to elderly on an ongoing basis comes from the informal sources of family and friends.

The Active Health Report - Perspectives on Canada's Health Promotion Survey, (1987) indicates that good to excellent self-rated health is the norm among seniors. Although there are higher rates of self-reported health problems among seniors, only one out of four seniors report fair or poor health while three-quarters report that their health is good to excellent for their age. Seniors possess tremendous capacities for coping and achieving health in everyday life.

The Federal Government document, Achieving Health for All: A Framework for Health Promotion (1986) portrays health as a resource or an essential dimension of everyday living which empowers people to make choices and gain satisfaction from their ability to manage and even change their circumstances within their environment. In endeavoring to meet the needs of an aging population especially with the challenges posed to both the formal and informal care sectors, empowerment of individuals and communities to assume greater responsibility for their own health and social needs will be crucial.

2.2 Factors Indicating Growth in Population Sectors

When setting priorities for program development, some indication of the growth of the population sector is required. Dependency ratios have been used to make rough comparisons between the productive and non-productive sectors of the population. In Canada, the age groups usually assumed to be dependent or non-productive are under 20 years old and over 64 years old. These groups are only estimates of dependence and productivity, as seven percent of those aged 65 and over are still working for pay and one quarter of those aged 20 to 64 are not (Baker, 1988). It is important to dispel the myth that the senior

population will become an insupportable burden on young Canadians based on dependency ratios.

Demographic profiles include statistical descriptions and analyses of populations to determine the numbers and distributions of people in a country or a region. These data are relevant for the development of government policy and effective administration.

2.3 National Demographic Aging

In 1986, 2.7 million Canadians were 65 years of age or more. This is a tripling of statistics from 55 years ago and represents a faster rate of growth than for the total population, which doubled in the same period. The main source of population aging is attributed to the dramatic increases in longevity (Stone and Fletcher, 1986). During the 1980's dramatic growth in the 75+ years subgroup was responsible for the greatest growth rate within the senior population.

2.4 Provincial Demographic Aging

The 1986 Census Report identified Prince Edward Island as the province having the highest percentage (12.7%) of seniors within its boundaries. It is expected that P.E.I. will maintain this leadership up to the year 2011 (Stone and Fletcher, 1986).

The present study utilized a P.E.I. projection model[1] for the Province and its counties, which was based on a moderate population growth scenario. Census data from 1986 provided a baseline for population projections up to the year 2001. Tables A and B (p. 9-10) are excerpts from this projection model for the years 1986, 1996, and 2001 (Source: Economic, Statistical and Fiscal Analysis Division, Department of Finance, P.E.I. Government).

Table A indicates the total number of those 65+ to be 16,090 (65-74 years = 9,205; 75+ years = 6,885), or 12.7 percent of the total Island population in 1986. Percentage-wise, seniors 65+ are increasing from 12.7% in 1986 to 13.1% in 1996 and reaching 13.3% in 2001. The corresponding projection in actual numbers is a total of 17,759 seniors 65+ in 1996, and a total of 18,524 seniors 65+ in 2001.

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1. This model provided the most accurate projection data available at the time of the study. In allocating projected numbers into county distributions the number difference is not statistically significant. At the time of the study Statistics Canada had not yet released its newest projection model.

TABLE A

P.E.I. PROJECTION
MODEL 1986 - 2001

	Age	M	F	Totals	% of P.E.I. Population
1986	0-24	26495	25090	51585	40.7
	25-44	18505	18525	37030	29.2
	45-64	10965	11005	21970	17.3
	65-74	4190	5015	9205	7.3
	75+	2750	4135	6885	5.4
	Total	62905	63770	126675	100.0
1996	0-24	24747	23271	48018	35.4
	25-44	21073	20850	41923	30.9
	45-64	13847	13985	27832	20.5
	65-74	4249	4927	9176	6.8
	75+	3287	5296	8583	6.3
	Total	67203	68329	135532	100.0
2001	0-24	24113	22828	46941	33.8
	25-44	20884	20196	41080	29.6
	45-64	15951	16267	32218	23.2
	65-74	4395	5045	9440	6.8
	75+	3455	5629	9084	6.5
	Total	68798	69965	138763	100.0

A look at the 65-74 and 75+ subgroups (Table A) within the data reveals some interesting trends. The figure for 1996 is 9176 persons, which is down by 29 people. The projection for the 65-74 year group in 2001 reflects minimal growth above the 1986 baseline, or 235 people for a total of 9440 people 65-74 years old.

In 1996, for the 75+ subgroup the projected figure is 8583 people or 1698 people above the 1986 baseline of 6855. For 2001, the 75+ group is projected at 9084 people or 2199 above the 1986 baseline. The 75+ subgroup is generally known to require more formal and informal supports for provision of care. The gender imbalance also becomes clearer in the 75+ subgroup (2001), as women begin to outnumber men by a ratio that approaches 2:1.

A more in-depth view of the counties also reveals some interesting trends for consideration in regional planning of programs for an aging population. Table B reflects demographic aging within the counties. The percentage breakdown of all seniors 65+ within the Province by counties is: 50% for Queens County; 33.7% for Prince County; and 16.1% for Kings County. It is projected that the population will shift slightly toward Queens County in the next decade. Queens County will have 53% of the total senior population in 1996 or 9367 people with a further increase to 54.1% by 2001 or 9985 people. Queen's County is the only county that will experience a percentage increase in the 65-74 age group. Both Kings County and Prince County are projected to have lower numbers in 1996. Prince County will have a minimal increase in the numbers within the 65-74 age group in 2001, while Kings County will experience an additional drop in the 65-74 age group in 2001.

TABLE B

POPULATION PROJECTION MODEL: COUNTY BREAKDOWN

		Queens Co.			Prince Co.			Kings Co.		
	Age	M	F	Totals	M	F	Totals	M	F	Totals
1986	0-24	12780	12300	25080	9400	8885	18285	4315	3875	8190
	25-44	9290	9850	19140	6425	6155	12580	2785	2525	5310
	45-64	5520	5665	11185	3665	3705	7370	1775	1630	3405
	65-74	2050	2530	4580	1405	1685	3090	735	790	1525
	75+	1285	2190	3475	995	1345	2340	470	600	1070
Total		30925	32535	63460	21890	21775	43665	10080	9420	19500
1996	0-24	12296	11668	23964	8525	8003	16528	3917	3569	7486
	25-44	10582	10946	21528	7267	6997	14264	3218	2911	6129
	45-64	6868	7192	14060	4701	4683	9384	2261	2098	4359
	65-74	2279	2714	4993	1420	1621	3041	600	612	1212
	75+	1605	2769	4374	1092	1718	2810	508	732	1240
Total		33630	35289	68919	23005	23022	46027	10504	9922	20426
2001	0-24	12187	11606	23793	8177	7730	15907	3746	3465	7211
	25-44	10523	10599	21122	7167	6774	13941	3192	2834	6026
	45-64	7960	8436	16396	5421	5438	10859	2520	2358	4878
	65-74	2402	2839	5241	1471	1653	3124	575	578	1153
	75+	1746	2998	4744	1140	1827	2967	504	740	1244
Total		34818	36478	71296	23376	23422	46798	10537	9975	20512

2.5 The Gender Imbalance in Population Aging

Within the aging population there is the presence of growing numbers of women as compared to men. In Canada and in Prince Edward Island women generally outlive men by five to eight years.

Women who were born in 1925, are now entering old age as it is defined in 1990. With few exceptions, these women were under more intense pressure than today's women to assume primary responsibility for the home and child care as their life work. The same women were raising their children in the

1940's and 1950's, in which there was heavy emphasis on the nuclear family with the father as sole breadwinner and the mother as homemaker. Many of these women did not return to the labor force after their children were born. On the occasion that women did work during this time period, they often worked in low income, low prestige and insecure jobs that seldom provided pension packages. More of these women, compared to women in subsequent generations, face retirement as widows with no pensions except for the Old Age Security/Guaranteed Income Supplement.

According to McDaniel (1986) this reality of scarcity of dependable resources for elderly retired women will likely continue for another twenty years at the national level. P.E.I. may not experience this similar trend as many Island women are employed in the private sector service industry where there are no pension plans. In the case of widows whose husbands had reasonably good pension plans, the death of the husband often results in discontinuance of the pension. For lifetime homemakers, despite their contribution to society by raising children, keeping house and attending to domestic needs there is no access to pensions of their own.

The poorest women among the elderly are those never married, widowed, divorced or separated. Changing pension regulations may assist in the resolution of some elderly women's poverty but problems will still remain. If pensions remain tied to a percentage of income, those on the lower scale will continue to suffer. Pensions are calculated as a percentage of annual income and women's work-related pensions are generally lower than men's because their incomes are only two thirds as large.

Although very closely tied to population aging, many of these issues will not be the target of specific recommendations in this study. Consideration of the gender imbalance has served as a conscious raising and educational purpose for Committee members and the potential audience that the report will attract. The issue of elderly women's dependency is a larger social issue reflective of their lower socioeconomic status. The issue of the demands on women as primary caregivers in the informal care system is addressed in the next chapter.

3. THE INFORMAL CARE SYSTEM

The informal care system is a primary support network that includes intergenerational and peer relationships among the elderly. Research has documented that 80% of care (emotional and service provision) comes from these informal sources. This section discusses the informal care system, identifies the issues of primary caregivers and provides direction for Government to facilitate the provision of care from this system.

3.1 Family and Friends

Historical interpretations of Society have led us to believe that the extended family was commonplace in pre-industrial Europe and North America. The portrayal of today's elderly as alienated from the family and frequently put in long-term care institutions provides a sharp contrast to the nostalgic view of the extended family. A closer examination of historical family arrangements reveals that the three generation family living under one roof with the elderly members providing wisdom and experience to the end was a temporary occurrence (Chappell, Strain and Blandford, 1986). What is historically consistent is that family relationships have traditionally provided and continue to provide a wealth of interpersonal support, warmth and dedication among all people. Social interaction is even more important when health begins to decline.

Help from family and friends has received attention recently because of increases in formal care costs for an aging population and also because of concern that current economic conditions will not allow the use of the current system by more and more elderly persons in future.

The aspect of volunteering to provide care for others is not new. The Government of Canada has shifted its concern to the potential role informal caregivers can play and has recognized the importance of this interface. (Government of Canada, 1982). Fry (1981) highlighted the high use of informal supports by the elderly on P.E.I. A study by Keefe (1986) also confirmed the importance of the relationship between the elderly and their supports on P.E.I. Keefe also indicated that the diminishment in numbers of the immediate family as primary support providers necessitates an examination of how other persons provide similar services. The community development component of Home Care and Support is addressing the need to create environments to facilitate appropriate community support.

3.2 Primary Caregivers

Many caregivers are aged such as the case of a devoted spouse caring for an ailing partner. Other primary caregivers may find themselves in the sandwich generation, required to give care to aging parents while still providing emotional and financial support to grown children. (Schlesinger, 1989).

The role played by daughters is well documented and also very different from the role sons play. The major responsibility for interpersonal sustenance and physical maintenance of elderly persons has fallen historically

to females. The direct services offered by daughters include assistance with personal care and household chores. Sons may be devoted but play a more substantial role in decision making or with financial assistance. The female primary caregivers often experience stresses related to the caregiving role. Emotional strains are considered highest, followed by restrictions on time and freedom. (Chappell et al, 1986).

These individuals providing care constitute a group at risk of deteriorating health.

> "Caregivers are just as vulnerable to health problems as their charges. Helping ... caregivers maintain their own health also contributes to the health of that other client - the frail elderly person who is dependent on others for his or her well-being. (Dellasega, 1989, p. 243)"

Supportive programs providing temporary relief from caring responsibilities as well as education must be made available to primary caregivers if they are to continue in their role.

Respite Care. This is a service that provides caregivers with intervals of relief from the demands of their caregiving roles. "For seniors living with the family, the difference between a tolerable situation and one that becomes unbearable is respite care" (Task Force on the Allocation of Health Care Resources, 1984, p. 21). A minimal respite care service is operated by the Division of Home Care and Support. The availability of regular relief to caregivers would decrease the incidence of hospital admissions and prevent premature placement in long-term care.

THE COMMITTEE ACKNOWLEDGES THAT AN INCREASED AVAILABILITY OF RESPITE OPTIONS IS A PRIORITY FOR FAMILY CAREGIVERS.

Education and Training. Caregivers can also be recognized and supported in their efforts to care for family members through training and education in the aging process.

THE COMMITTEE RECOMMENDS:

- **THE DEVELOPMENT OF EDUCATIONAL SESSIONS ON THE AGING PROCESS FOR PRIMARY CAREGIVERS.**

Day Programs. Day programs are services in a congregate setting that enhance the daily lives of older people and support their continued involvement in the community. Services range from social and health related, to the provision of active rehabilitation, and physical and mental health care. Some caregivers may wish to maintain their employment options. Day programs are one service that would permit this. A day program with extended hours of service could be beneficial for clients requiring two meals and an earlier/later start, and to caregivers who work early morning or late afternoon shifts. Adult day programs are available on a limited basis in P.E.I. (see section 4.4.1 p. 45). The P.E.I. Division of the Canadian Mental Health Association is beginning a day program for persons with Alzheimers and other dementias. It is suggested that expansion of day programs could greatly benefit people who wish to live in the community rather than in an institution. There is also the additional benefit of containment of health care costs for the provincial government.

THE COMMITTEE SUPPORTS THE CONCEPT OF DAY PROGRAMS TO OFFER PREVENTIVE PROGRAMS THAT BOTH ENHANCE THE INDEPENDENCE OF SENIORS AND PROVIDE SUPPORT TO FAMILY CAREGIVERS.

4. THE FORMAL CARE SYSTEM

Health problems are commonly experienced by the elderly. The formal care system is the societal response to health care needs. It assumes responsibility on the part of society to provide care for those needs. The formal care system is composed of all governmental, profit and non-profit service agencies as well as health and other professionals and paraprofessionals that work within the system. This includes traditional medical services - physician and hospital, long-term care, community and social services, home care and community care, that may be provided within a government program or by non-profit and for profit agencies. Health services are defined in a broad sense when delivered through the formal care system.

4.1 Physician Services

The general practitioner has traditionally been the main provider of physician services to the elderly population on Prince Edward Island. This group of physicians is experiencing the impact of an aging population as greater numbers of seniors require increasing amounts of physicians' time.

It is suggested that the 65-74 and 75+ age groups consume a significant amount of physician services. (Table C, p. 19). This disproportionate use of physician services is occasionally viewed as problematic but it becomes more logical if one considers that when seniors do develop health care needs, often they are chronic disorders requiring long-term caring and frequent contacts with physician services.

TABLE C

NUMBER OF MEDICAL SERVICES BY AGE FOR ALL IN-PROVINCE SERVICES

AGE GROUP	87-88	% OF TOTAL	88-89	% OF TOTAL	RATE OF GROWTH
0 - 19	215,449	22.1	234,717	22.1	8.9
20 - 64	482,841	49.4	527,513	49.6	9.3
65 - 74	120,678	12.4	133,955	12.6	11.0
75+	157,384	16.1	166,506	15.7	5.8
	976,352		1,062,691		

Source: P.E.I. Hospital and Health Services Commission

Education Needs. The release of the P.E.I. Medical Personnel Report in August of 1988 revealed that many Island physicians felt they were not meeting the total needs of the elderly and were receptive to further education. CMA (1987) advocates that there are problems in effective continuing medical education in geriatric medicine for both family physicians and specialists. There must be a cooperative effort between the provincial associations and the continuing medical education departments of Canadian Medical schools to develop continuing medical education programs that will be innovative and effective in reaching practitioners who wish to update their knowledge of geriatric medicine. In carrying their recommendations a step further CMA (1987) states: "That provincial governments give high priority to funding appropriate continuing education programs in geriatric medicine." (p. 42)

THE COMMITTEE RECOMMENDS:

- **THAT THERE BE ATTRACTIVE OPTIONS/OPPORTUNITIES FOR GENERAL PRACTITIONERS TO OBTAIN SPECIALIZED EDUCATION IN GERIATRICS.**

Geriatric Specialty. The specialty of geriatrics evolved as a response to the needs of an elderly population. In other provinces, the elderly

population has some access to the services of a geriatrician[2], as well as specialized in-patient units in the form of geriatric assessment units. "The geriatrician should be a resource person for the family physician, ready to act in a consultative and directive role as well as to offer continuing care in specialized units" (CMA, 1987, p. 40). It must be emphasized that specialized geriatric services do not seek to assume primary care of the elderly - even the frail elderly, but rather to support the family physician in prevention, diagnosis, treatment, rehabilitation and continuing care of his/her elderly patients. In an effort to deliver geriatrician services on a larger scale, new specialists in geriatric medicine will have to be recruited and trained (CMA, 1987).

THE COMMITTEE IS SUPPORTIVE OF THE SEARCH FOR THE SERVICES OF A GERIATRICIAN TO PROVIDE LEADERSHIP, DIRECTION FOR IMPROVED GERIATRIC CARE AND CONSULTATION TO PHYSICIANS.

The strain on existing physician services could also be alleviated by the addition of nursing practitioners to primary health care teams. Such personnel could implement health promotion programs and assist in the reorientation of the delivery of health care to a preventative focus (Association of Nurses of P.E.I., 1989).

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2. An academic consultant in geriatric medicine that is recognized by the Royal College of Physicians and Surgeons of Canada. This requires two years of additional training in geriatrics after completion of three years in internal medicine. Canadian programs currently graduate a total of eight geriatricians per year (CMA, 1987).

4.2 Hospital Services

Hospital Bed Distribution. The elderly on P.E.I. have access to a hospital system composed of two major acute care centers and five smaller community hospitals located in rural communities. Table D on page 21 provides information on the distribution of provincial hospital beds. The hospital system is presently under review through the implementation of the Hospital Role Study. This study is a cooperative effort between the P.E.I. Medical Society, the Hospital Association of P.E.I. and the P.E.I. Hospital and Health Services Commission. A segment of the Hospital Role Study will be devoted to the development of a health care implementation strategy responsive to the needs of an aging population.

TABLE D

REGIONAL BED DISTRIBUTION IN ACUTE CARE

Alberton	O'Leary	Tyne Valley	S'side	Ch'town	Montague	Souris	Totals
50	33	23	162	351	50	25	694

(Source: Preliminary Data, Bed Distribution Comparison Document, Panel on the Hospitals Role Dec., 1989)

High Utilization of Hospital Beds. The utilization rates for in-patient services for the Province are shown in Table E. Provincially, seniors 65+ account for 30.2% of all hospital admissions.

TABLE E

UTILIZATION STATISTICS: NO. OF ADMISSIONS & READMISSIONS IN ACUTE CARE HOSPITALS, P.E.I., 1987-88

Age	No. of Admissions	% of Total	Readmissions
0-64	18,563	69.8	4,173
65-74	3,883	14.6	1,259
75+	4,149	15.6	1,588
Totals	26,595	100.0	7,020

It is generally acknowledged that, while the aged as a whole are heavy consumers of acute hospital services, high utilization can be attributed to a very small proportion of seniors who are admitted frequently for long stays. Some literature from other provinces suggests that just 5 percent of the elderly consume 59 percent of the hospital days used by the elderly. Is it not appropriate to begin dispelling the thought of a deluge of elderly upon the health care system and replacing it with a plan for potentially targeting a small group of patients for special preventive or service delivery measures? In the absence of specific data pertaining to P.E.I., plans for alternate service delivery measures (such as community health screening clinics) cannot be developed for this group.

THE COMMITTEE RECOMMENDS:

- **THAT THIS GROUP OF ELDERLY AT RISK OF FREQUENT ADMISSIONS MUST BE STUDIED FURTHER.**

Care of the Elderly in the Acute Setting. The current approach of our care delivery system is illness-oriented. Such a system encourages the elderly to seek access to services once problems have arisen or reached a stage where they can no longer cope. Elderly patients are encouraged to be

passive and dependent while necessary treatments are undertaken. The emphasis is on diagnosis, treatment and cure rather than on rehabilitation. When the indicated treatment is completed, the elderly remain hospitalized because suitable care is not available elsewhere. In the case of some elderly, an episode of acute illness is associated with a loss of functional ability and thus results in their inability to return to the same level of independence in their living situation. "Because of this system of delivery of health care services to the elderly and the specialized health care needs of the elderly, particularly those over age 85 years, it is recognized that appropriate rehabilitation care is not always being provided in acute care hospitals" (P.E.I. Hospital and Health Services Commission, 1988, p. 9).

TO PREVENT FURTHER DECREASES IN FUNCTIONAL ABILITY OF GERIATRIC PATIENTS THE COMMITTEE RECOMMENDS:

- **THAT THE FOCUS OF CARE WITHIN ACUTE CARE SETTINGS SHOULD BE TOWARD REHABILITATION OF THE GERIATRIC PATIENT**
- **THAT CONSIDERATION SHOULD BE GIVEN TO THE DESIGNATION OF SHORT-TERM GERIATRIC REHABILITATION BEDS IN THE ACUTE CARE SECTOR**
- **THAT HOSPITAL STAFF WHO ARE EMPLOYED IN THESE SETTINGS SHOULD RECEIVE SPECIALIZED EDUCATION IN GERONTOLOGY AND FUTURE STAFF POSITIONS SHOULD BE CONSIDERED AS NEEDING THIS BACKGROUND**

Service Inadequacies. Specialized geriatric assessment units were introduced to Canada by way of Britain approximately 20 years ago. The thrust of comprehensive geriatric assessment is to restore the aged sick person to a degree of health which will permit his/her return to independent living. The P.E.I. Hospital and Health Services Commission document Proposal for Geriatric Assessment and Rehabilitation Unit (1988) provides evidence for the need of a

Geriatric Assessment Unit. "The sickness intervention model, common in our present health care system, does not always provide the full spectrum of care required to meet the needs of the elderly" (p. 2).

THE COMMITTEE IS SUPPORTIVE OF THE ESTABLISHMENT OF A GERIATRIC ASSESSMENT UNIT ON P.E.I.

THE COMMITTEE RECOMMENDS:

- **THAT THE GERIATRICIAN AND GERIATRIC ASSESSMENT UNIT BE UTILIZED IN A RESOURCE CAPACITY FOR INFORMATION AND IN CONSULTATION OF THE CARE OF THE ELDERLY ON THE ISLAND.**

- **THAT THIS BE ACCOMPLISHED THROUGH THE LINKAGE WITH ACUTE AND REHABILITATION IN-PATIENT BEDS THROUGHOUT THE ISLAND HOSPITAL SYSTEM, HOME CARE AND SUPPORT TEAMS, OR ASSOCIATED DAY PROGRAMS.**

Case Management. Coordination of care or case management of the elderly person within the health care system is a major concern of the many care providers within the system. CMA (1987) takes a firm position on advocation for coordination of care of the elderly within a health care system that has a broad range and complex array of services that may be delivered by community based services or within institutions. This concern was reiterated to the Aging Impact Committee by the representatives from the Hospital and Health Services Commission, the P.E.I. Hospital Association and also in the brief as presented by the Association of Nurses of P.E.I. Without proper management of care many geriatric patients may be left occupying acute care beds because of lack of placement options. Long-term occupancy of beds within acute care by geriatric patients may deny access to beds by more acutely ill patients. This latter situation may be a greater concern of the two larger acute care centers (Prince County Hospital and Queen Elizabeth Hospital). In the smaller rural hospitals there may not be the same degree of concern in accessing beds but appropriate placement is still a priority concern.

Some hospitals are attempting to lessen long-term acute care stays among the elderly through a cooperative effort of designated hospital staff and community resource personnel. The objective of the effort is to encourage an appropriate discharge plan for the geriatric patient to: (1) independent living; (2) independent living with support from Home Care; (3) convalescent care; (4) supervised residential accommodations; or (5) supportive nursing care.

TO PREVENT LONG-TERM STAYS IN ACUTE CARE THE COMMITTEE RECOMMENDS:

- **THAT THERE SHOULD BE DESIGNATION OF APPROPRIATE HOSPITAL AND COMMUNITY PERSONNEL TO INITIATE EFFECTIVE DISCHARGE PLANNING FOR THE ELDERLY IN ALL ISLAND HOSPITALS.**
- **THAT THESE EFFORTS BE COORDINATED WITH PERSONNEL IN LONG-TERM CARE.**

Changing Care Requirements. The care requirements of some elderly are reflective of advancing medical technology. More patients are benefiting from oxygen therapy. When these patients are ready for hospital discharge there is confusion as to living options available if they are not returning to their private place of residence. There are also limited long-term care options for patients who require tube feedings and I.V. therapy. It is not within the scope of this study to address ethical issues surrounding advances in technology versus quality of life, however, the placement of patients with increased medical-nursing care requirements must be addressed during the next decade. (A recommendation pertaining to this issue is found in the long-term care section.)

4.3 Community-Based Programs

Community-based programs are services or programs which are offered outside an institutional setting. There are a variety of programs in the structure of the Department of Health and Social Services (i.e. Community Mental Health, Division of Nursing), as well as community-based organizations. The terms of reference for the Aging Impact Study have dictated that the Committee study the impact of an aging population on the Division of Home Care and Support.

4.3.1 Division of Home Care and Support

Scope and Mandate. The Division of Home Care and Support was established in 1985, partially in recognition of service fragmentation and limited opportunities for co-ordination and service consistency province wide. Most of the services that were formally organized under Home Care and Support had existed in various government divisions for several years but were available only to select groups and in certain areas, mainly on a daytime, weekday basis. There was recognition within the Health and Social Services fields that home based care and support systems must be a major thrust of future planning. Fry (1981) clearly identified the need for services that would enable senior citizens to remain in their own homes whenever possible.

The Division of Home Care and Support integrates health and social support services; i.e. Home Care Nursing, Occupational Therapy, Visiting Homemaker, Community Support, Adult Protection, and on a limited basis Physiotherapy. Service potential is maximized through the teamwork approach.

The organization of the Division is decentralized to five regions, providing consistent team components throughout the province. The three functional models of Home Care are present in P.E.I.'s Home Care program. These include: (1) the acute care substitution function which meets the needs of people upon hospital discharge who may require health and/or social support to enable them to return home; (2) the extended care substitution function which assists elderly clients to maintain their independence in their own homes for as long as possible; (3) the rehabilitation function where services are provided to people of any age who have physical or medical deficits.

The services of Home Care and Support are intended to help people help themselves. They are not a replacement of what the family or community normally does for itself, rather they bridge the gap between what the family can provide and what the client actually needs. The services are intended to help in a crisis, to relieve the family caregiver, to offer additional support that helps people remain in their own homes or to assist in returning home if they have been receiving care in a hospital or other setting.

Service Demand and Delivery. The demand for Home Care and Support services has increased yearly since its inception. If Home Care and Support is to be successful in its mission to support people in their own homes, required services must be provided at the right time and in the right amount.

Home Care and Support has observed the trend of many frail elderly people wanting to remain independent in their own homes, despite the fact that in many cases their quality of life has deteriorated. Many are willing to live at risk and accept a lower standard of living to maintain their autonomy and enhance their self-worth.

An important component of providing effective Home Care and Support services to the elderly is the identification of client needs through comprehensive geriatric assessment. The ablility to identify high risk clients and provide these clients with additional services, could help to prevent crisis situations that can lead to use of hospital emergency departments, in-patient services or inappropriate long-term placement.

Homemaker Services. The Visiting Homemaker caseload has observed a trend toward more referrals for personal care requirements. There are presently 743 clients receiving Visiting Homemaker services of which 279 receive personal care. Initially, the Visiting Homemaker program reflected referrals for household chores. This trend indicates that as the elderly become more frail and less independent, they will seek

increased homemaker services on a daily or twice daily basis. Home Care and Support has developed policies that guide monitor maximum service provision.

Respite Care. Home Care and Support services have identified a remarkable increase in the number of family caregivers seeking respite care services within their own homes. In many situations this involves an aging spouse or a daughter who is struggling to cope with the constant demands of caring for their ailing partner or parent. In some situations caregivers are sacrificing their own health in caring for a person suffering from Alzheimer's or other type of dementia or from a chronic disabling condition. Presently Home Care provides 2-4 hours of respite to these families once or twice a week. This allows the family member to attend to matters outside the home, engage in some social activities or sometimes just have a rest. Some families would prefer respite services in the evenings or on weekends, but Home Care and Support is not currently able to respond to these type of requests.

Families who can afford to hire privately to relieve family caregivers are doing so. Requests are received on a regular basis for names of private individuals who are interested in working with seniors in their own homes. There is a shortage of individuals willing to live in with seniors or to stay during the nighttime hours. It is difficult to find private help by the day for these families who can only afford to pay the minimum wages. There are regular inquiries regarding the availability of subsidization of private help for seniors to enable them to remain in their own homes.

THE COMMITTEE RECOMMENDS:

- **THAT THERE SHOULD BE THE DEVELOPMENT OF A CARE-GIVER SUBSIDIZATION PROGRAM THAT COULD OFFER FINANCIAL ASSISTANCE TO OFFSET THE COST OF RESPITE CARE WITHIN THE FAMILY HOME BASED ON FINANCIAL NEED.**

The Visiting Homemaker service is cost shared on a 50/50 basis with the federal government under the Canada Assistance Plan, which necessitates that all clients requesting this service be income tested. Clients are critical of the sliding fee scale in place for the Visiting Homemaker services. Some consumers believe that these services should be provided free of charge to the elderly, to enable them to remain in their own homes. Staff perceive the fee positively as they feel it serves as a deterrent and helps encourage some clients to discharge services as soon as possible.

Palliative Care. There is an increase in the number of terminally ill elderly clients receiving support services in their own homes. Home Care and Support works closely with the Island Hospice Association in identifying the need for services and in reviewing the clients progress. These clients receive priority for services and as their illness progresses usually require extended Home Care Nursing and Visiting Homemaker services. Pain control, physical comfort and family support are the main elements of concern. Some clients and family members have difficulty receiving the medical support they require at this time and sometimes experience poor pain control management, which often necessitates them moving to an acute care setting or a palliative care unit.

There is a need for family physicians to have more knowledge and understanding of pain control in the terminally ill. A gerontologist consultant could provide direction in the areas of palliative care and pain control (Island Hospice Association, 1989).

Costs to Clients. Many elderly clients receiving the basic OAS/GIS who require Home Care Nursing services for palliative care or otherwise, express financial difficulty in obtaining the necessary supplies. These could include dressings, catheters, syringes and needles, colostomy supplies, incontinent pads, high protein liquid and pain control medication, etc. This is especially evident if services are required for an extended period of time. The cost of supplies may be a factor in transferring to a palliative care unit or a hospital where no costs are involved. Clients would be willing to pay for the supplies but find the retail rate too costly.

THE COMMITTEE RECOMMENDS:

- **THAT CONSIDERATION BE GIVEN TO THE PURCHASE OF BULK MEDICAL NURSING SUPPLIES IN ORDER TO PROVIDE SUPPLIES AT A LOWER COST TO SENIORS.**

Home Care Nursing. As medical technology increases, the requests to advance more complicated nursing procedures within the home for elderly clients continues to grow. Home Care Nurses are now trained in kidney dialysis, home oxygen care, venous access ports, orthopedic day surgery, follow-up, narcotic infusion (pumps for the terminally ill), T.P.N. and selected vascular surgery techniques. Many of these procedures require an advanced level of skill and in-service training for Home Care Nurses.

Home Care Nursing receives many requests to provide foot care to seniors. Because of the demand, guidelines had to be developed to restrict services to those suffering from circulatory problems of the feet, diabetes or blindness. Many clients seek referral from their family physician. As of November 30, 1989, 307 clients were receiving foot care services from Home Care and Support. It has been observed that many elderly neglect their feet and only seek assistance after they begin to experience pain or discomfort. Some clients had received services from the podiatrist. Home Care Nursing provides foot care services at no cost. An issue facing Home Care is the decision to charge for foot care. As well, there are many seniors not receiving foot care. (This problem further addressed under Foot Care and the Elderly, page 63).

Community Development. There has been much progress made in the area of community development. Community group activity has been influenced by the availability of monies to fund projects through the Senior Independence Program, as well as the Mill River "Yes We Can Conference," and the presence of the Community Support Workers as resource persons to these groups in the community.

The Community Support Worker is the link between the formal and informal care system. In most situations, they plant the seed, then act in a resource capacity by providing direction, leadership and on-going support for the project. It is essential that continued emphasis be placed on the volunteer sector to play a major role in developing support services for seniors. With leadership and direction provided by

Government, the communities can be supported in developing support services to meet identified needs for seniors in their own communities through church groups, service clubs, etc. There are examples of services that have been developed at the community level such as Meals on Wheels, Community Response Programs (developed under contract by Red Cross), transportation services, friendly visiting, Lifeline projects, Seniors Infoline, day/respite program for people with Alzheimer's disease, and Caregivers Support Groups. This function of Home Care which generates community supports to enhance the resource base for clients is essential to extend the capacity of seniors to remain in their homes and communities.

Physiotherapy Services. Presently, there are no physiotherapists on the regional teams. The intent was to purchase physiotherapy services from the hospitals when they were required. This service is virtually nonexistent due to staff shortages within the hospital system.

Given that 80% of the caseload are seniors and many over 80 years of age, activation and mobility programs are needed to encourage independence following orthopedic surgery, skeletal injuries, general surgery and compensation for general loss of function due to immobility. The addition of physiotherapy would greatly benefit the elderly and help them remain active and more independent within their own homes. The committee spent considerable time in discussion of the issues regarding physiotherapy services. There are benefits to the services of physiotherapy for the elderly throughout the formal care system, clearly the first step must be provision of adequate numbers of therapists.

THE COMMITTEE RECOMMENDS:

- **THAT THE RECRUITMENT OF PHYSIOTHERAPISTS SHOULD BE ACTIVELY PROMOTED AS A PROVINCIAL INITIATIVE.**

Adult Protection Act. With the passing of the Adult Protection Act (1988), adult protection services were added as a component of the Home Care and Support Team. During the first year of implementation of this service, it has become clear that service demand is much higher than anticipated. Staff time required to coordinate multi-disciplinary assessments and provide follow-up service is increasing. Sensitively trying to understand the views of those in need, consulting with other care providers and mediating with families requires time - time that cannot be rushed. Staff throughout the province are recognizing the need for extra training due to the complexity of many of these situations.

There has been a mixture of response to the Adult Protection Act (1988) on Prince Edward Island. Many individuals and agencies believe it is a positive piece of legislation which balances the needs of adults at risk while still respecting individual rights. Others believe that it does not go far enough in permitting the Home Care agency to intervene in situations where individuals appear to be very vulnerable.

Coordination with Other Services. Because of the diverse nature of Home Care and Support services, it is essential that this Division has a strong linkage with the Acute Care Sector, Long-Term Care Sector, Medical Services, and other government agencies and community services.

Home Care and Support has established an effective method for communicating and working closely with the acute care sector through the role of the Hospital Liaison Nurse. In some areas, the Hospital Liaison Nurse visits the hospital daily, participates in ward conferences and is involved as part of the discharge planning team. This linkage ensures that clients who will be requiring Home Care and Support services on discharge are identified early. Planning for the necessary in-home support services is efficiently arranged, thus promoting a smooth flow of clients from one sector to another.

There is presently no formal mechanism that allows for an ongoing exchange of information between Home Care and Support and the placement officers of the Division of Aging and Extended Care. Home Care and Support provides services to many clients immediately prior to their admission to a nursing home or community care facility. They may or may not be aware that the client is being considered for nursing home placement. In some situations, the staff of Home Care could provide the placement officers of Aging and Extended Care with valuable information and observations from their involvement with the client that would assist them in completing their functional assessments.

Home Care and Support has recognized the need to encourage family physicians to make house calls to the frail and house-bound elderly. In the aging population physicians will likely be requested to make more calls to homes.

Home Care and Support works closely with the Community Mental Health Division. There is a significant number of elderly clients who suffer from some form of mental illness, often times resulting in various levels of confusion and/or paranoia. The client can present problems not only for themselves but for family members or neighbors who may be concerned or at risk because of their behavior. The staff in Mental Health are very cooperative in carrying out mental health assessments and sharing their observations and recommendations with the staff of Home Care and Support. There appears to be a shortage of mental health workers to perform follow-up and counselling services.

THE COMMITTEE RECOMMENDS:

- **THAT MORE EMPHASIS BE PLACED ON THE PROVISION OF PSYCHOGERIATRIC SERVICES TO THE ELDERLY IN THE COMMUNITY.**

Home Care and Support is required to work closely with the Division of Child and Family Services. Financial assistance is sometimes sought on behalf of some elderly clients who cannot afford necessary health care items, e.g. oxygen generator, wheelchair, private help, etc. Many elderly who have supported themselves all their lives, find it degrading to have to apply for financial assistance at this stage in their lives. The end result is subsidization of home health care under General Welfare Assistance and not through the health sector.

4.3.2 The Future Direction of Home Care and Support

There are many indicators that point to the fact that the demands to increase home care services will continue for some time. The most obvious one is the increasingly elderly profile of the population. We know that those 60 and over are presently using about 81% of home care services.

Another reason for growth in Home Care is that public demand for this type of service is increasing, as people become more and more concerned about quality of life issues and correspondingly less inclined to allow themselves or their family members to be admitted to institutional care. Because more frail elderly that require higher levels of care are staying home there will naturally be a surge in demand for home care programming.

Hospitals are now placing more emphasis on ambulatory surgery, similarly, shorter lengths of stay in hospital are being encouraged, which again will lead to increased demands for Home Care services.

Finally, many of the technologies that previously could only have been provided in an institutional setting have become more portable and much easier to be administered by family members and client themselves. There will be a greater increase in the potential for providing these

forms of care in home settings. This is evidenct in the use of oxygen generators, Narcotic Infusion Pump control, and venous port systems, etc.

Comprehensive Home Care services are relatively new additions to the health care system. Home care expenditures comprise less than 2% of total health care system expenditures on P.E.I., despite increased demand for services. Home Care remains a minor component of the health budget. In the future the factors of: (1) the increased aging rate of the Island population (2) provision of heavier levels of care outside nursing homes; (3) increased referrals from acute care, (both inside and outside the province); (4) and the decrease in the actual rate of expansion of nursing home beds will necessitate expansion of the home care program. The evolution of home based services must be carefully planned and managed and above all, coordinated with the acute and long-term sectors.

THE COMMITTEE RECOMMENDS:

- **THAT CONSIDERATION BE GIVEN TO INCREASED FUNDING FOR HOME CARE AND SUPPORT.**

4.4 Long-term Care Services

Long-term care services include an array of public and private facilities that provide a level of service on a 24-hour basis. On-site personal and supervisory care services and/or nursing services are available for residents.

4.4.1 Division of Aging and Extended Care

Scope and Mandate. The Division of Aging and Extended Care has undergone significant changes and accepted new administrative responsibilities since its original inception in 1971. The Division is now the central administrative structure for the operation of seven homes and manors, the Dr. Eric Found Health Centre and Hillsborough Hospital and Special Care Centre, and the Community Care Facilities and Nursing Homes program.

There has been a 17% growth in nursing beds from 499 in 1980 to 582 in 1989, or 83 beds. This growth is generally reflective of the opening of Wedgewood Manor (76) and a small increase in the number of beds at Beach Grove Home (7).

TABLE F

DIVISION OF AGING AND EXTENDED CARE

Extended Care Institutions	Beds
Dr. Eric Found Health Centre	63
Hillsborough Hospital & Special Care Centre	191
Total	254

Government Nursing Homes:	Long-term Care	Respite Care	Total
Maplewood Manor	50	1	51
Wedgewood Manor	75	1	76
Summerset Manor	119	1	120
Prince Edward Home	95	1	96
Beach Grove Home	130	2	132
Riverview Manor	50	1	51
Colville Manor	54	2	56
Total	573	9	582

Eric Found Centre. Following, the addition of the Dr. Eric Found Health Centre, a Role Study recommended a reorganization of designated beds to respond more appropriately to the needs of the community in general and to Queen Elizabeth Hospital in particular. This reorganization designated 15 beds for convalescence care, 8 palliative beds for care of the terminally ill, 22 long-term medical nursing beds (for those requiring ongoing medical supervision) and 18 long-term nursing home care beds (for persons under age 60). Progress has been made in the movement of patients from the Queen Elizabeth Hospital, most notably in the use of the 15 convalescent beds and the 8 palliative care beds. Admission criteria for convalescent care beds necessitates that potential residents must have a discharge plan back to the community. A new aspect of case management while still in acute care is an ongoing

monitoring of patient progress to determine if the patient will qualify for the admission criteria. With ongoing monitoring another opportunity is afforded for movement from the acute care setting at the appropriate time. The Liaison Nurse representing the Division of Aging and Extended Care and Home Care and Support at the Queen Elizabeth Hospital has demonstrated the importance of such a linkage in the efficient, appropriate movement of patients through the system. Three years ago some long-term medical patients may have been in hospital for one year awaiting placement. Efforts are being made to discharge long-term patients from the Dr. Eric Found Centre into more appropriate settings and allowing admissions of more long-term applicants.

Hillsborough Hospital. Hillsborough Hospital has two psychogeriatric units which total 43 beds. Many of these residents are elderly and require nursing care. The unique administrative linkage of Hillsborough Hospital with the Division of Aging and Extended Care was the subject of one segment of the Mental Health System Review (1988). An ad hoc committee has been established to follow-up with the recommendations of the 1988 Review.

As long as seniors on P.E.I. suffer from dementias such as Alzheimer's Disease or have major disabilities and infirmities that require a particular level of service, then there will be a need for placement in Manors and Homes for the aged. Following an assessment of functional status persons are classified according to need, placed on the waiting list and assisted in obtaining interim services if necessary.

All applicants are required to complete a financial statement which will determine their ability to pay wholly or in part, the cost of their care. Government is prepared to subsidize up to 100% of all residents for their cost of care. Generally, residents contribute their Old Age Security/Guaranteed Income Supplement less a comfort allowance of $75.00. A centralized Admissions Committee within the Division of Aging and Extended Care approves all admissions. This allows for a single point of resident entry into the Government Homes and Manors.

Service Demand and Delivery. Information on both priority wait lists and total applications made to all manors for the last decade is presented in Table G. For the purpose of the present study a snapshot view of average time on the Government wait list was undertaken. As of September 28, 1989, the average time on the wait list for the last 50 admissions to Government Homes and Manors was determined to be 78 days or 2.6 months. Further examination of the same data set revealed that 60% of the admissions were from the hospital system, the remaining 40% were admitted from either private home, seniors apartment housing or Community Care Facility. Wait lists can fluctuate. In August of 1989 there were 23 patients at Queen Elizabeth Hospital awaiting placement. By January 1st, 1990 this had reduced to 1 applicant.

TABLE G

GOVERNMENT HOMES WAIT LIST

		Priority	Total	%
AS OF APRIL 1:	1981	59	524	11.2
	1982	72	566	12.7
	1983	112	589	18.7
	1984	121	612	19.7
	1985	100	585	17.1
	1986	127	608	20.9
	1987	132	692	19.1
	1988	68	661	10.1
	1989	80	714	11.2
AS OF FEBRUARY 1,	1990	63	684	9.2

The need and desirability of increasing the extended care capacity in Prince County and the possible need for government sponsorship of such expansion was addressed in 1985. The DPA consultant group recommended the construction of a new 144 bed manor facility by 1991 for all of Prince Edward Island. This was based on the 1985 priority wait list of 94 persons plus the population projections.

During 1989 there has been consistent pressure from acute care for priority placement to nursing home for applicants within West Prince. The majority of these applicants were in acute care settings. The consistent pressure created by the wait list in this region is

understandable when one considers that only 51 beds are available to the population in the West Prince area, compared to Kings County which has double the amount of nursing care beds for a similar size population.

The philosophy of the Homes and Manors of the Division of Aging and Extended Care has always recognized that residents living within institutions deserve the best possible care provided in a homelike atmosphere. The team approach within the facilities endeavors to meet psychosocial, physical and spiritual needs while encouraging independence.

The special needs of confused and wandering suffering from Alzheimers and other dementias are also addressed within the Manor System. Four facilities have designated units. Intensive inservice has been offered to divisional staff in all facilities. Increased demand for care of the cognitively impaired is expected to continue.

Respite care beds are designated in all facilities. (See Table F). If short-term care is indicated, seniors may be admitted to a manor for a period not to exceed 30 days in any 12 month period. Applications must be processed through a Placement Officer of the Division of Aging and Extended Care. All necessary assessment criteria must be completed prior to admission. There is a fee (maximum OAS/GIS) that is charged for this service. The actual cost to the temporary resident will depend on required contributions to maintain private living arrangements within the community. This service was utilized at 34% of its capacity in 1988/89. The committee spent considerable time attempting to determine

the reasons why this service is under-utilized. Factors such as cost, admission procedure and perceived inflexibility may be deterrents to program use. A successful program must be easily accessible on short notice for families in crises situations. Longer term respite beds, i.e. for two months per year as opposed to one month and a system of rotating respite beds which is currently available in other provincial jurisdictions are more responsive to primary caregivers' needs (Alzheimer's Society of P.E.I., 1989). Community staff should be aware of this program.

THE COMMITTEE RECOMMENDS:

- **THAT THE RESPITE CARE PROGRAM WITHIN THE DIVISION OF AGING AND EXTENDED CARE SHOULD BE MORE ACTIVELY MARKETED AMONG PROFESSIONALS AND ISLAND RESIDENTS.**

- **THAT THE DIVISION OF AGING AND EXTENDED CARE COLLABORATE WITH THE DIVISION OF HOME CARE AND SUPPORT TO ENSURE THAT PRIMARY CARE GIVERS HAVE ACCESS TO THESE BEDS.**

- **IF THERE ARE DEMANDS FOR VARIATIONS ON THE RESPITE PROGRAM THESE SHOULD BE MADE KNOWN TO THE PLACEMENT OFFICERS WITHIN THE DIVISION OF AGING AND EXTENDED CARE FOR CONSIDERATION OF PROGRAM OPTIONS.**

Day Programs are operated in some Manors. Varying levels of service are offered to seniors, based on community need and the availability of resources. In Montague, Home Care and Support provides a program using Division of Aging and Extended Care Facilities. Programs offer opportunities for social activities, meals, education and support sessions for participants and their families and referral services for consultation with counsellors, nutritionists, therapists, and medical/nursing personnel. There is presently a review underway of the Brecken House Day Program with a view to establishing future direction and service need for this program.

THE COMMITTEE RECOMMENDS:

- **THAT THE NEED FOR DAY PROGRAMS WITHIN THE DIVISION OF AGING AND EXTENDED CARE SHOULD BE DETERMINED BEFORE EXPANSION OCCURS.**

Levels of Care. The average age of admission to manors within the 1980's was approximately 82, which is significantly different than the 70 year old average age of admission in 1972. The original bed designations for seniors within manors was that half of the beds would be for seniors requiring heavy or nursing care (levels 3-5) and half would be for seniors needing light care (levels 1-2).

The trend toward admission of more frail elderly plus the normal aging of residents within the manors contributed to a shift toward heavier levels of care within all manors. Table H provides information on this shift from 1983-1989.

TABLE H
LEVELS OF CARE - ALL MANORS

Care	1983	1984	1985	1986	1987	1988	1989
Light	47%	39%	35%	29%	25%	23%	18%
Heavy	53%	61%	65%	71%	75%	77%	82%

The Government policy response to deal with the shifting trend plus the added variable of an increasing wait list (see Table G, p.43) for priority nursing care was to convert existing manor "up care" beds (Levels 1-2) to nursing care beds (Levels 3-5). A strategic plan aimed at increasing the staffing complement within Homes and Manors was developed by senior management within Aging and Extended Care.

Beginning in fiscal year 1987-88, the plan was presented to Treasury Board and Cabinet for approval. Submissions followed in subsequent fiscal years with different facilities benefiting from the increased funding. Thus, heavier care nursing residents were admitted into existing bed stock.

4.4.2 The Future Direction of Aging and Extended Care

Advances in health care technology have resulted in a placement challenge for the Division of Aging and Extended Care. The Admissions Committee of Aging and Extended Care has received requests for placement of manor care patients that require continuous oxygen therapy and other medical/nursing treatments. These patients deserve the right to a secure environment. Maintaining these patients in acute care is costly. Their holistic care requirements could be more appropriately managed in a long-term care facility. A program responding to these care requirements will necessitate reorganization of units, re-alignment of personnel and the addition of professional nursing staff.

THE COMMITTEE RECOMMENDS:

- **THE ESTABLISHMENT OF SMALL UNITS WITHIN NURSING HOMES AND MANORS TO CARE FOR RESIDENTS WITH INCREASED MEDICAL/NURSING NEEDS SUCH AS CARE OF I.V. THERAPY, GASTRIC TUBE FEEDINGS, AND CONTINUOUS OXYGENATION. THESE UNITS SHOULD BE APPROPRIATELY FUNDED AND STAFFED.**

The addition of medical/nursing treatments within the manors could also decrease short-term admissions to acute care. More so than ever, residents are peacefully experiencing the final stage of life by dying

in the familiar surroundings of the Homes and Manors. A review of 1989 data revealed that 75% of all deaths occur in the Homes and Manors. Families continually need assurance that their relatives, in the majority of cases, do not need to be admitted to hospital.

There are many arguments for and against a centralized model of assessment and admissions. Other sectors may conclude that there is much bureaucratic red tape regarding financial assessment and that there appears to be inflexibility within the system. Presently the Division of Aging and Extended Care contends that only priority nursing care applicants (frail elderly and seniors with dementias requiring specialized care) are accessing available nursing care beds. The Division of Aging and Extended Care also acknowledges that increased demands for service delivery may necessitate a re-evaluation of a centralized model of assessment and admissions to Government Homes and Manors.

4.4.3 Private Nursing Homes

There are nine facilities ranging in size from 13 to 135 beds, operated by private sector entrepreneurs or non-profit religious organizations. All facilities practice autonomous admission policies. All Homes are licensed and regulated by the Community Care Facilities and Nursing Homes Board. The growth in the private sector has increased by 33 beds in the last 5 years. Requests for expansion within this sector usually originate with the operators' desire to expand based on a wait list, a perceived need for service within the community or on a

business basis venture. Wait lists are not accurate indicators of need for nursing beds as some names may appear on several of the facilities wait lists. The Division of Aging and Extended Care conducted a survey of all private sector homes in September of 1989. An analysis of all wait list data determined that the true number of Island residents awaiting priority placement within private nursing homes was 23 people.

Non-Profit Religious Homes. Government is prepared to provide financial assistance to all nursing care beds within non-profit facilities. As of January 30, 1990, 123 residents out of a total of 163 received financial assistance in non-profit homes. All policies of the Department of Health and Social Services regarding the finances of applicants for a Government Home or Manor also apply to those residents of private nursing homes applying for financial assistance. A monthly comfort allowance is also made available for the personal comforts of the residents.

TABLE I

NON-PROFIT RELIGIOUS HOMES

	Available for Subsidy	Non-Subsidized	Total Beds
Sacred Heart Home	135	0	135
Sunset Lodge* - Nursing	28	0	28
Total	163	0	163

* This facility also has 44 community care beds.

Non-profit Homes have also experienced an increase in the care requirements of their residents. Sunset Lodge, as a dual facility has experienced an ongoing problem with ability to transfer residents from the Community Care section to Nursing Care when such care was required. For example, 15 of the 44 community care beds are currently occupied by residents who should be in beds designated for nursing care. This has the effect of stopping any admissions from the Community to nursing care at Sunset Lodge. The major issue from the non-profit sector is the desire of Sunset Lodge to have designated community care beds converted to nursing care beds. The administration of Sunset Lodge suggests that a conversion of community care beds to nursing care beds would address the needs of those residents in the community care section who require nursing care. The eventual benefit of an addition of nursing care beds to the general long-term care system would only be realized as these beds were made vacant for new admissions from the community.

The costs of operation within non-profit organizations have increased substantially over the last decade. Expansion of nursing beds within the non-profit sector could necessitate Government commitment for subsidy of all residents requiring nursing care.

<u>For-Profit Homes</u>. Since 1975-76 Government has implemented a 50% - 1 subsidization policy for residents within for profit homes. Residents must be self-paying for the initial three months of their stay. All policies of the Department regarding the finances of applicants for a Government Home or Manor apply to those residents of nursing homes requesting financial assistance. Subsidized residents are eligible for the comfort allowance.

TABLE J

FOR-PROFIT NURSING HOMES

	Available for Subsidy	Non-Subsidized	Total Beds
Garden Home	49	51	100
P.E.I. Atlantic Baptist	33	34	67
Lennox Nursing Home	13	15	28
MacMillan Lodge	7	9	16
Perrin's Clinton View Lodge*	6	7	13
Whisperwood Villa*	16	18	34
Gillis Lodge*	6	7	13
TOTAL	130	141	271

* Denotes a facility providing community care in addition to nursing care.

These Homes have also seen the profiles of their residents change and move toward increasing heavier levels of care. There has been great cooperation among the private sector and the Government Homes sector, in responding to the special needs of residents. Private facilities have a difficult time caring for wandering and confused residents while Government Homes are capable of accepting these residents and have specialized units for their care. The for-profit Homes have been responsive to residents requiring continuous oxygen therapy.

These for profit homes have also experienced the increased price tag that goes along with providing heavier levels of care. Their per diems range from a low of $50.00 per day to a high of $70.87 per day. All homes have experienced a substantial increase in per diems over the last decade. There are additional costs for nursing supplies, drugs,

and other services. Expansion in this area must be sensitive to the market potential of self-paying guests. Presently, approximately 54 per cent of residents in the for-profit sector are self-paying.

4.4.4 Community Care Facilities

Community care facilities provide supervisory and personal care (Levels 1 and 2) to residents. During the 1970's there were frequent room and board arrangements of clients that were less than favorable with no legislation for the setting of standards. In 1981 a joint committee from Government and Industry was commissioned to examine the situation. This committee recommended that legislation for inspections and licensing of homes providing some form of care be developed. The Community Care Act & Regulations were developed by 1984. The original intent was that these facilities providing care to 5 or more residents would be extensions of the community and provide a homelike environment while allowing the operator to make a living. The last five years has been a period of tremendous growth in the community care facility industry. The number of beds has grown from 287 to 628. The original intent to have small homelike facilities has not been realized. Slightly more than 50% of community care facilities are now capable of housing 20 to 76 residents. The suitability of the present legislation is in question.

THE COMMITTEE RECOMMENDS:

- **A REVIEW OF THE EXISTING ACT AND REGULATIONS FOR COMMUNITY CARE FACILITIES WITH RESPECT TO SIZE OF FACILITIES.**

Community care has generally provided a less costly option for those individuals requiring supervisory and personal care (i.e. Levels 1 and 2). It is suggested that government could potentially save dollars by encouraging a preventive focus within the community care system. The maintenance of the functional ability of individuals could delay progression to nursing care and prevent government expenditure on subsidization.

THE COMMITTEE RECOMMENDS:

- **THAT THERE SHOULD BE INCREASED EMPHASIS ON PREVENTIVE EDUCATION PROGRAMS WITHIN COMMUNITY CARE FACILITIES FOCUSING ON THE AREA OF NUTRITION, DRUG AWARENESS AND ACTIVATION PROGRAMS THROUGH THE UTILIZATION OF COMMUNITY NURSES, COMMUNITY OCCUPATIONAL THERAPISTS, PHYSIOTHERAPISTS, NUTRITIONISTS AND PHARMACISTS.**

The initial rates within community care facilities were as low as $350 - $400 per month. The present rates range from 590 - 2000 per month. The rate escalations are indicative of the rapid expansions of some facilities coupled with newly constructed facilities coming on line. The competition created among the facilities necessitated a certain amount of upgrading of facilities. While this was somewhat positive in terms of physical attractiveness of facilities, the resultant increases in the rates left many potential residents unable to afford them.

THE COMMITTEE RECOMMENDS:

- **THAT THE CCF-NH BOARD SHOULD ENCOURAGE THE LICENSING OF SMALLER FACILITIES (5-10 BED) AS ONE MECHANISM TO PROMOTE AFFORDABLE CARE.**

The Aging Impact Committee was presented with the concern of "affordable" community care facilities in a number of the submissions. The development of this situation has created pressure on Government to subsidize community care over and above what is provided through the Welfare Assistance Program. The Committee spent considerable time in discussing the issue of affordable community care. It was determined that the need for a general subsidy for all residents within community care was not justified. However, the current system of subsidization through the Welfare Assistance Act with provision for subsidy at $610.00 to $760.00, is not adequate.

THE COMMITTEE RECOMMENDS:

- THAT THE PROVINCIAL GOVERNMENT SHOULD NOT PROVIDE A GENERAL SUBSIDIZATION TO COMMUNITY CARE FACILITIES BUT CONTINUE TO SUPPLEMENT LOW INCOME SENIORS THROUGH THE WELFARE ASSISTANCE PROGRAM.

- THAT THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES REVIEW ITS PRESENT PROCESS OF SUBSIDIZATION.

- THAT THERE MUST BE AN IMMEDIATE INCREASE IN THE SUBSIDY TO REFLECT THE INCREASING RATES WITHIN COMMUNITY CARE FACILITIES PLUS A BUILT IN MECHANISM FOR REGULAR INCREASES IN THE SUBSIDY.

4.4.5 The Future Direction of the Long-Term Care Sector

A discussion of future health care resources as related to the supply of institutional care beds for the elderly was addressed by A Task Force on the Allocation of Health Care Resources (1984). This report suggested that improvement in quality of life for the elderly must be addressed through reduction in the institutionalized rate from the current national rate of 9.45% to 6.0%. The report assumed that the capping off of institutional options would be supplemented over time by increases in Home Care Programs. The policy of the Government of P.E.I. to hold a moratorium on the addition of nursing are beds to the total system since 1987 has in effect slowed the institutionalization of seniors and followed a scenario similar to that suggested by A Task Force on the Allocation of Health Care Resources (1984).

The province of Alberta has reduced the number of nursing care beds from 70 per 1000 residents over 65 years to 65 beds per 1000 residents over 65 (allowing an institutionalization rate of 6.5% within facilities providing nursing care).

A logical sequence for expansion of the supply of nursing home beds in P.E.I. should consider nursing beds in relation to census data from 1981 and 1986 and the future population projections of 1991, 1996 and 2001. This information is provided on Tables K & L.

TABLE K

CENSUS DATA COMPARISON AND NURSING BED EXPANSION

Year	Population over 65 years Seniors	Number of Nursing Beds Public and Private	The Ratio of Nursing Beds per 1000 over 65	%
1981	14,895	499 + 401 =900	60	6.0
1986	16,090	582 + 419 =1001	62	6.2

TABLE L

PROJECTION OF NURSING BED REQUIREMENTS 1991-2001

Year	Population Projection for 65 yrs and over	Number of Nursing Beds to maintain 60:1000 ratio	Increase in nursing beds above present supply, or 1016 in 1990
1991	17,054	1023	7
1996	17,759	1066	50
2001	18,524	1111	95

Table L indicates a ratio of 60 nursing beds per 1000 people over 65 years of age for the years 1991, 1996 and 2001. The availability of data from the next national census in 1991 would provide a check on the accuracy of the population projection used to provide the example in this report.

THE COMMITTEE RECOMMENDS:

- **THAT THIS LOGICAL SEQUENCING OF DATA SHOULD INDICATE THAT AN APPROXIMATE 100 BED EXPANSION IS NEEDED WITHIN THE NEXT DECADE. THIS COULD OCCUR IN SYSTEMATIC ADDITIONS TO THE PRESENT SYSTEM WHERE CONSISTENT PRESSURE HAS SHOWN A NEED. IT HAS BEEN THE EXPERIENCE OF THE PAST DECADE THAT AN APPROPRIATE PUBLIC AND PRIVATE MIX OF FACILITIES HAS SERVED THE POPULATION WELL AND PROMOTES A LEVEL OF COMPETITION TO PROVIDE QUALITY CARE.**

- **THAT IF THERE IS EXPANSION WITHIN THE PRIVATE SECTOR THEN THE OPERATORS MUST BE SENSITIVE TO THE CHANGING NEEDS OF ISLAND ELDERLY, I.E. NEED FOR A SECURE ENVIRONMENT FOR WANDERING AND CONFUSED AND THE INCREASING MEDICAL NURSING NEEDS BASED ON ADVANCES IN MEDICAL TECHNOLOGY.**

Living Options. Traditional types of expansion are but one option. Some creative options are suggested in the next discussion of an Adult Foster Care Program, Satellite Nursing Homes and the Adopt-a-Grandparent Program.

Adult Foster Care. This program could offer the choice of foster family living for adults in P.E.I. who require a level of care (Levels 3 to 5). Individuals can maintain the experience of independent community living in the safety and security of a certified foster family home.

A program of this type is offered as one option in the continuum of long-term care in Arizona, U.S.A. The Adult Foster Care Program certifies foster homes and screens potential residents for foster family living. Residents contribute their monthly income and are eligible for subsidization, subject to financial disclosure. Program staff provide support and supervision to both families and residents during placement. Adult Foster Care Homes are required to be certified and subject to inspection. Sponsors must also complete required training each year.

Sponsor families gain personal satisfaction, companionship and an opportunity for participation in an industry by providing care for up to four individuals. In exchange for a monthly fee paid by the resident, family sponsors provide room, level of care, meals and emotional support to residents who qualify for the program.

The Division of Aging and Extended Care could provide support and guidance for the development of such a program in the private sector. The main benefits to such a program would be the enhanced quality of life for the individual who remains in the homelike environment and the potential cost savings to government as subsidy for nursing care within this option would be less costly than established private nursing homes and Government Homes and Manors.

Satellite Nursing Homes. The establishment of satellite homes or units that could provide care to a small number, 5-10 residents, should be considered. It is suggested that this option could be an extension of the present Government Home and Manor System, administered and staffed by the core unit. These Homes could be rented or purchased in areas near existing Homes and Manors.

This would prevent government from having to construct costly homes. The approach would also allow for graduated care and flexibility in resource usage. Some recent research on approaches to caring for the cognitively impaired suggest that these residents function much better in a small, quiet environment.

Adopt-A-Grandparent Program. This is another community option that would allow an elder individual requiring a level of care (Levels 1-2) to live with a carefully matched family. Sponsor families could gain personal satisfaction, companionship and an opportunity to earn

extra money by providing personal and supervisory care to the adopted Grandparent. A formalized program could assist in the recruitment of adoptive families and in the matching of Grandparents.

5. RELATED HEALTH CARE ISSUES

This next section examines related health care that necessitates some contact with the formal care system, and potentially impact on seniors' ability for independent living. Concerns and issues are identified. Future direction is proposed.

5.1 Medication and the Elderly

Medications are a necessary component in the treatment of chronic disease within the elderly population. Many improvements in treatment regimens are the result of advances within pharmacological research. However, concern has been repeatedly expressed about the untoward events that can occur in the elderly because of excessive or inappropriate use. Untoward events include failure of an expected drug response, excessive dosage, and increased sensitivity or failure to metabolize and excrete medication.

The issues around drug prescribing and use in the elderly surfaced as major concerns at two recent Canadian Health Care Conferences. These issues include multiple drug use, compliance, packaging and cost. At both conferences, "Challenges and Changes" and the "International Conference on Quality Assurance and Effectiveness in Health Care", strategies to improve prescribing patterns were viewed as major steps to improve the quality of health care delivered to the elderly population and their subsequent ability to experience independent living.

Multiple Medication Use. Fry (1981), identified a significant percentage of the senior citizens who were interviewed 'at risk' because of multiple drug use. Twenty-five percent of respondents were taking three or more different drugs. Information from a National Conference on Medication Use in the Elderly (1987) indicated that the elderly, composing 10% of the Canadian population, account for 40% of prescribed medications, as well as a high proportion of non-prescription "over-the-counter" medication use. The Canadian Medical Association indicates that presently, between 10 percent and 15 percent of patients over 65 years of age who are admitted to hospital suffer from drug-induced conditions. Medications may also be prescribed by two or three doctors treating the same patient for different conditions without knowing what the other physician has prescribed. The CMA (1987) document on "Health Care for the Elderly - Today's Challenges Tomorrow's Options", takes a strong stance on drugs and the elderly. It recognizes the unique aspects of drug therapy in the elderly. As well, the elderly are known to have three times the incidence of adverse reactions to drugs than do younger patients. The possibility of adverse drug reactions is increased with multiple drug treatment of multiple diseases.

Medication Compliance. Compliance with a recommended drug regimen is also a factor. Many community nurses have discovered elderly patients with difficulties in remembering instructions on use and the purpose of the medication. Also an elderly individual living alone may be lacking the prompting of an interested person to suggest when medications should be taken.

THE COMMITTEE RECOMMENDS:

- **THAT THERE SHOULD BE IMPROVED STRATEGIES FOR THE EDUCATION OF SENIORS, CAREGIVERS AND PROFESSIONALS REGARDING THE KNOWLEDGE AND UNDERSTANDING OF THE USE OF MEDICATIONS.**

- **THAT THERE SHOULD BE IMMEDIATE IMPROVEMENT IN THE MONITORING PRACTICES OF ALL HEALTH AND SOCIAL SERVICES PROFESSIONALS REGARDING MEDICATION USE IN THE ELDERLY.**

- **THAT THE FOCUS OF THESE INTERVENTIONS BE TOWARD HEALTHY AGING.**

Pharmacists can play an active role in educating the public regarding medication use. The pharmacist is often more readily available than the physician to respond to medication related questions.

Medication Packaging. Packaging can pose problems for many elderly. The elderly who have physical disabilities as a result of arthritis find it difficult to open certain containers or packages. Those with poor vision have difficulty reading computerized labelling. CMA (1987) suggests that present computerized pharmacy systems within the private sector could be linked to area pharmacies to provide individual drug profiles. Such a system linkage could reduce the probability of hoarding drugs or prescribing incompatible medications.

THE COMMITTEE RECOMMENDS:

- **THAT IN AN EFFORT TO PROMOTE INCREASED RESEARCH, THE P.E.I. PHARMACEUTICAL ASSOCIATION IN PARTNERSHIP WITH THE P.E.I. MEDICAL SOCIETY AND THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES BE ENCOURAGED TO SECURE A SENIORS' INDEPENDENCE GRANT FOR FUNDING OF A MAJOR STUDY TO IMPROVE THE DISPENSING, CONTROLLING AND COUNSELLING REGARDING MEDICATION USE IN THE ELDERLY.**

Medication Costs. As a response to the high cost of medications, Prince Edward Island implemented the Drug Cost Assistance Plan for Seniors in 1987. The availability of effective high-quality medications for the elderly through provincial drug benefit programs is recognized as valuable. The P.E.I. program charges user fees of $10.35 per prescription. This program had a budget of $2.3 million for the 1988-89 fiscal year. This was based on 10,400 seniors requiring an average of 15 prescriptions per year at $13.00 per

prescription. The Drug Cost Assistance Program for the 1989-90 fiscal year was increased to $2.8 million based on 1988-89 data. In 1989, the average cost of a prescription rose to $21.77, while the cost increase incurred by seniors was .20¢. Although the cost of medications continues to increase, the Drug Cost Assistance Plan ensures seniors will experience minimal increases in their user fees.

5.2 Foot Care and the Elderly

Foot care problems arise or become worse with the normal aging process. This is often aided by the complication of arthritis in adult life. Many of the elderly may also suffer from dysfunctional or deformed feet which limits their mobility and independence. A recent survey of seniors in Saskatchewan revealed that approximately one quarter of those surveyed had serious walking problems (Brodie, 1989). Healthy feet certainly contribute to an active and independent life for seniors.

One podiatrist[3] offers foot care services on a fee for service basis out of an office located in Charlottetown. For seniors receiving the maximum Old Age Security and Guaranteed Income Supplement, the cost of foot care is considered an expensive frill. Physical accessibility to the service may also be an added concern to seniors who are reliant on others for transportation.

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3. A health professional specializing in treatment of conditions of the foot.

Preventive foot care services have advanced because of the commitment of the Department of Health and Social Services to have nurses appropriately trained. Since 1985, four nurses from the Department of Health and Social Services have completed Basic and Advanced Courses in Foot Care, conducted by Dr. George Merry, a Geriatrician from Kingston, Ontario. These nurses have provided direct services (assessment and intervention) within their sectors (community and long-term care) and have promoted ongoing education regarding foot care.

The Division of Home Care and Support does provide foot care services (See page 32). The challenge is upon the Division to provide additional services.

A nationwide training program "Keeping Canadians on their Feet", made possible through Seniors Independence Program grant to the Victorian Order of Nurses, has as its objective the availability of preventive foot care services to a greater portion of the senior population. A nurse from Home Care and Support has participated in this high risk, podiatrist approved foot care training. The additional training of other nurses in this program could result in a consistent Island-wide service that conforms to standards of approved foot care.

THE COMMITTEE RECOMMENDS:

- **AFFORDABLE, UNIVERSALLY ACCESSIBLE FOOT CARE, PROVIDED BY APPROPRIATELY TRAINED NURSES.**

6. HOUSING AN ELDERLY POPULATION

The availability of affordable and adequate housing is central to the ability of senior citizens to maintain their independence for as long as possible. This section examines the present housing situation of seniors, identifies current problems and issues, and proposes future directions for government.

6.1 The Range of Present Options

Homeownership. The predominate form of housing for Prince Edward Island seniors is Homeownership. According to the 1986 Census, approximately 72% of the senior led households (more than 6,700 households) were living in units which they owned.

Generally, the rate of homeownership among seniors is considerably higher in rural areas than in the urban areas of greater Charlottetown and Summerside. The most frequent problem experienced by senior homeowners relates to their housing conditions, and the rate of homes needing major repairs is almost three times higher in rural areas than urban.

The P.E.I. Housing Corporation has estimated that at least one-quarter of the senior citizen homeowners are living in homes that are below minimum health and safety standards, and considering their relatively low, fixed incomes, a very significant segment of the senior homeowners cannot afford to

improve their living conditions. Present federal and provincial programs do not adequately respond to the home repair needs of lower income senior citizens.

In addition to a requirement for basic home repair assistance, there is also a requirement for assistance to undertake home modifications. Many seniors, as a result of the aging process, experience imfirmities and/or disabilities that restrict their capability to live independently. Frequently, independence can be maintained by undertaking adaptations or modifications to the housing unit. Examples of possible modifications would include the installation of grab bars, ramps, special fixtures, wider doorways, etc. Similar to the situation with home repairs, many lower income seniors are unable to afford the cost of needed modifications.

Senior citizen homeowners appreciate the sense of security offered by ownership and a very high majority want to remain in their own homes for as long as they are able. Since the cost of maintaining seniors in homeownership is extremely cost effective relative to the provision of other housing options, it is also in governments' interests to offer programs and services which will allow seniors to remain in their homes. With this in mind,

THE COMMITTEE RECOMMENDS:

- **THAT THE PROVINCE, EITHER UNILATERALLY OR IN CONCERT WITH THE FEDERAL GOVERNMENT, PROVIDE FUNDING TO INTRODUCE A BASIC HOME REPAIR PROGRAM FOR LOWER INCOME SENIOR CITIZENS LIVING IN SUBSTANDARD HOUSING.**

- **THAT THE PROVINCE, THROUGH THE HOUSING CORPORATION, INTRODUCE A PROGRAM TO ASSIST LOWER INCOME SENIOR CITIZENS UNDERTAKE HOME MODIFICATIONS THAT ELIMINATE BARRIERS TO INDEPENDENT LIVING.**

Rental Housing. There are presently about 2,600 senior citizen households[4] residing in rental accommodation. Of these 2,600 households, about 47% are living in government subsidized housing. 1,102 households live in Senior Citizens Housing units directly administered by the P.E.I. Housing Corporation and about 125 households reside in senior units operated by private non-profit groups.

The approximately 1,400 senior households living in private market rental accommodation have significantly different housing problems than their counterparts who own. These households tend to have lower incomes, fewer assets, and higher housing costs than seniors who own their homes. Where seniors in homeownership most frequently have a problem with their housing conditions, the primary problem of seniors in the private rental market is housing affordably, i.e. having to pay a very significant portion of their incomes toward housing. These households are also concentrated in the greater Charlottetown and Summerside areas.

Over the last ten years, the Province has placed a significant emphasis on the construction of Senior Citizens Housing. As a result of these new units coming on line and of tenant turnover in existing units, the Housing Corporation has seen its applicant waiting list for Senior Citizens Housing decline appreciably. More specifically, only four communities (Charlottetown, Summerside, Souris and Montague) continue to show a strong demand for Senior

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4. This figure does not include seniors who are living in collective dwellings (e.g. nursing homes, manors, hospitals, convalescent homes, rooming houses, etc.).

Citizens Housing and the waiting list for all other locations is extremely limited. In fact, the Housing Corporation is experiencing long-term vacancies in several locations.

THE COMMITTEE RECOMMENDS:

- **THAT THE FUTURE CONSTRUCTION OF SENIOR CITIZENS HOUSING BE DIRECTED TO THOSE COMMUNITIES WHERE THERE IS EVIDENT NEED AND DEMAND.**

The Housing Corporation has also noted some significant changes in its Senior Citizens Housing tenant population over the years. The average age of tenants is presently 76 years old and is increasing gradually each year. As well, there are fewer "younger" tenants and more elderly tenants. Almost 40% of the present Senior Citizens Housing tenants are over 80 years of age.

These changes have important implications in terms of future costs to government. Until now, the Housing Corporation has been able to rely on its younger senior tenants to provide basic maintenance (sweeping and vacuuming) for the common areas of projects. In addition, these younger tenants often provide informal support and assistance to the older tenant population.

The Housing Corporation is already seeing many cases where its elderly tenants are experiencing difficulty in performing normal tasks usually associated with independent living (e.g. cleaning, cooking, changing light bulbs, etc.) With fewer younger tenants to help out, there will inevitably be an increasing reliance on outside supports.

THE COMMITTEE RECOMMENDS:

- **THAT THE HOUSING CORPORATION, TOGETHER WITH THE DIVISION OF HOME CARE AND SUPPORT, INVESTIGATE AND DEVELOP INNOVATIVE AND COST EFFECTIVE WAYS OF PROVIDING SERVICES AND SUPPORT TO ITS ELDERLY SENIOR CITIZENS HOUSING TENANTS.**

6.2 FUTURE HOUSING OPTIONS

A number of newer housing options have been used extensively in some parts of the country but are just starting to develop in P.E.I. (e.g. condominiums and co-operative housing). Other alternatives such as garden suites, life interest leases, homesharing and home equity conversion programs are now in the process of being developed, tested and refined in other provinces. Some of these options may be of interest to P.E.I. seniors and quite possibly could result in reduced demands on government, if offered by the private sector to those seniors who have the financial capability of solving their own housing problems.

Prince Edward Island's first **CONDOMINIUMS** were developed in Charlottetown approximately a year ago, and it is noteworthy that the predominant take-up of these privately developed units has been by senior citizens. This housing form may appeal to senior homeowners who have high equity in their present homes and who are no longer able and/or wish to contend with the problems of traditional homeownership.

The present federal **CO-OPERATIVE HOUSING** Program was introduced in 1986, and provides residents with security of tenure and a direct say in the management of their project. While many seniors do not wish to accept the responsibilities associated with co-operative living, others appreciate the sense of security and control it offers. There are, however, limitations to this program as only 15 units per year are available for delivery in P.E.I. and these units are not specifically targeted to seniors. Therefore, the opportunity for expansion is limited.

A GARDEN SUITE is a mobile, self-contained unit that allows for independent living. The unit is usually placed in the yard of the senior's family so that any needed support can be provided by family members. This option potentially has some application in rural communities where the long-term demand for a Senior Citizens Housing unit is questionable. When the garden suite is no longer required at one site, it can be relocated to another. A second factor making this option more applicable to rural areas is the planning by-laws of many municipalities which often prohibit the location of a garden suite on the same site as an existing home.

HOMESHARING is an option that allows two or more individuals to remain in independent living while sharing expenses. This does occur naturally on P.E.I. among some age groups but is not popular with seniors. Homesharing is more common in those parts of the country where housing costs are exceptionally high, thus forcing seniors to be more accepting of this type of approach.

The **LIFE INTEREST LEASE** concept is relatively new and has been piloted in Canada by the Saskatchewan Housing Corporation. Under this option, a non-profit organization (could be the Housing Corporation or a private non-profit group) develops a project and rents a portion of the units, usually about 50%, to low income seniors on a rent geared-to-income basis. The non-subsidized units are made available to seniors on a rent free basis in return for purchasing a financial interest in the project. The non-subsidized seniors still pay a monthly charge covering their share of the normal operating expenses (e.g. taxes, utilities, maintenance, etc.). When leaving the project, the non-subsidized seniors recapture their original investment,

usually at an appreciated value. This option is in many respects similar to a condominium and may appeal to seniors who have high equity in their homes and who no longer desire traditional homeownership.

HOME EQUITY CONVERSION options are offered by private financial institutions and offer senior homeowners an opportunity to increase their incomes. Essentially, the financial institution will provide the senior with a monthly payment of a negotiated amount and in return will take a financial charge in the form of a registered mortgage against the senior's property. Although this option has been used with moderate success in some countries, it has not been popular with Canadian seniors as they are reluctant to take on debt.

Alberta Mortgage and Housing Corporation's **LODGE PROGRAM** for Seniors is a variation of our province's Senior Citizens Housing Program. It provides lower income seniors with a bedsitting unit (with bathroom) and has centralized kitchen, dining and lounge facilities. On-site staff are responsible for meal preparation, cleaning of common areas and general maintenance. Residents of these projects must be capable of independent living as personal services and/or support is not provided, i.e. this is not a community care facility. Monthly rental charges are determined based on the resident's income and an additional charge is levied for meals.

In May of this year, the P.E.I. Housing Corporation, together with Canada Mortgage and Housing Corporation, will be sponsoring a two and a half day conference on future housing alternatives for senior citizens. The conference will provide participants, the majority of whom will be seniors,

with an opportunity to consider and evaluate a wide variety of housing options. The feedback received through this conference should be extremely helpful in determining possible future housing directions in P.E.I.

THE COMMITTEE RECOMMENDS:

- **THAT THE P.E.I. HOUSING CORPORATION FULLY EXPLORE THE FEASIBILITY OF HOUSING OPTIONS ENDORSED BY THE CONFERENCE, POSSIBLY THROUGH THE DEVELOPMENT OF PILOT DEMONSTRATION PROJECTS.**

- **THAT IN DEVELOPING INNOVATIVE HOUSING OPTIONS, THE HOUSING CORPORATION CONTINUE TO TARGET ITS ASSISTANCE TO THE MOST NEEDY SEGMENT OF THE SENIOR POPULATION (THOSE WITH THE LOWEST INCOMES AND ASSETS, HIGHEST HOUSING COSTS, WORST HOUSING CONDITIONS, ETC.).**

- **THAT THE HOUSING CORPORATION INVESTIGATE WAYS OF ENCOURAGING THE PRIVATE SECTOR TO DEVELOP INNOVATIVE HOUSING ALTERNATIVES FOR THOSE SENIORS WHO HAVE THE FINANCIAL CAPABILITY OF SOLVING THEIR OWN PROBLEMS.**

7. A COORDINATED SYSTEM OF CARE FOR THE ELDERLY

This multi-sectoral information review of the present governmental health and social service programs related to the impact of an aging population has proposed a number of important options and strategies. Our present system has grown as needs were identified. As a result, many diverse organizational structures and several disciplines have become involved each with its own set of criteria, standards of service and procedures for delivery. For the future, our task is to ensure a comprehensive continuum of care desirable for and by seniors. The mere addition of services, even the ultimate development of the Geriatric Assessment Unit will not ensure quality of life for seniors. The experience of the Aging Impact Study Committee affirms the belief of the need to rank planning and coordination as first and second priorities.

The Aging Impact Committee has also identified the need for an educative, health promotional approach to be incorporated into Prince Edward Island's care delivery system. The present system has socialized individuals throughout the lifespan to seek access to the system once health problems develop. For the elderly, services may be accessed in crisis situations when they can no longer cope.

Moving toward a health focus within a care delivery system demands that we must begin to educate the public throughout the life cycle. Health promotional strategies are needed to show people how to lead healthier lifestyles. Education on nutrition, exercise, stress responses, safety

behaviors and self-care is needed to facilitate individuals to achieve their optimal health potentials within the greater context of their environments. The earlier the focus on healthy lifestyles begins, the greater impact it will have on the health of individuals.

The elderly can also be assisted to focus on the positive aspects of their health and can implement behaviors to preserve these. The operating principle of well baby clinics in the present care delivery system of P.E.I. provides a model to begin well elderly clinics or health assessment centers that can provide a health focus in the delivery of care to the elderly. Nurses are the largest group of the major players within the health care team that are available to implement such a strategy. A combined team of nurses, occupational and physical therapists, social workers and nutritionists has the knowledge, expertise and health teaching ability to provide services that could enhance the health of the elderly.

The Department of Health and Social Services. The simplicity of the administrative structure of the Department of Health and Social Services allows for a direct, efficient coordination mechanism. Over the past 2 years joint policy formation and program development among the divisions occurs through regular meetings of the Deputy Minister and the Directors of the Division. Seminars, program reviews, annual budget planning and the interdivisional ad hoc committees also assist in the process. Inter-agency collaboration at the field work level must be improved through the establishment of a formal mechanism for information sharing. Divisions and

agencies offering programs/services to seniors must not operate in isolation. This coordination demands the development of guiding philosophy and set of principles for program development and service delivery.

Closely tied with the aspect of coordination is the establishment of linkages. As an example of this, the Division of Home Care and Support has initiated a strong linkage with the general hospitals in the acute care sector. The Division of Home Care and Support has also identified that the evolution of home based service must also be linked with the long-term sector. The Division of Home Care and Support and the P.E.I. Housing Corporation have also identified common ground for improving services to the elderly.

Innovative mechanisms for establishing coordination of services to the elderly need to be designed and tested. Some factors that require consideration are the comprehensive assessment of elderly individuals by service providers and a single point of entry to long-term care services.

Comprehensive Geriatric Assessment. This refers to an assessment that is a holistic evaluation of the client. It is an assessment that occurs at a community based entry point to determine the client's level of family and community support in order to plan for services needed. The Committee recognizes that assessment is occurring within various Divisions/Agencies providing services to seniors.

THE COMMITTEE RECOMMENDS:

- **THAT AN AD HOC COMMITTEE COMPOSED OF MEMBERS FROM DIVISIONS/AGENCIES PRESENTLY INVOLVED IN ASSESSMENT OF SENIORS SHOULD BE FORMED TO DEVELOP A COMPREHENSIVE ASSESSMENT TOOL THAT COULD BE UTILIZED BY ALL PROFESSIONALS TO ASSIST IN ASSESSMENT AND PLACEMENT FUNCTIONS.**

Single Point of Entry to Long-term Care Services. A single point of entry to long-term care services is the response to the need for a coordinated assessment and placement system to streamline entry to the service. An initial assessment of clients requesting long-term care placement is conducted by community-based program personnel. The goal is to ensure the appropriate use of community services wherever possible and that all community supports are to be exhausted before admission to long-term institutional care. Community assessment and the subsequent placement within long-term institutional care are considered separate functions.

Other provinces (i.e. Alberta, New Brunswick and Newfoundland) have implemented a Single Point of Entry to long-term care services. The implementation of these models appears to be a viable alternative for the improved coordination of services. The Aging Impact Study Committee recognizes that there are various models of single point of entry to services, as well as differing interpretations of what constitutes long-term care services.

THE COMMITTEE RECOMMENDS:

- **THE ESTABLISHMENT OF A STUDY GROUP TO DETERMINE THE MOST APPROPRIATE SINGLE POINT OF ENTRY MODEL FOR P.E.I.**

CONCLUSION

Throughout this identification and assessment of issues pertaining to the impact of an aging population, the importance of coordination and planning have been emphasized.

The development of strategies to respond to the impact of an aging population has translated into recommendations for all players within the informal and formal care systems and other related sectors. These recommendations provide direction for the development of coordinated health and social policy.

RECOMMENDATIONS

THE COMMITTEE RECOMMENDS:

1. THE DEVELOPMENT OF EDUCATIONAL SESSIONS ON THE AGING PROCESS FOR PRIMARY CAREGIVERS.

2. THAT THERE BE ATTRACTIVE OPTIONS/OPPORTUNITIES FOR GENERAL PRACTITIONERS TO OBTAIN SPECIALIZED EDUCATION IN GERIATRICS.

3. THAT THE FOCUS OF CARE WITHIN ACUTE CARE SETTINGS SHOULD BE TOWARD REHABILITATION OF THE GERIATRIC PATIENT

4. THAT THE GROUP OF ELDERLY AT RISK OF FREQUENT ADMISSIONS MUST BE STUDIED FURTHER.

5. THAT CONSIDERATION SHOULD BE GIVEN TO THE DESIGNATION OF SHORT-TERM GERIATRIC REHABILITATION BEDS IN THE ACUTE CARE SECTOR

6. THAT HOSPITAL STAFF WHO ARE EMPLOYED IN THESE SETTINGS SHOULD RECEIVE SPECIALIZED EDUCATION IN GERONTOLOGY AND FUTURE STAFF POSITIONS SHOULD BE CONSIDERED AS NEEDING THIS BACKGROUND

7. THAT THERE SHOULD BE DESIGNATION OF APPROPRIATE HOSPITAL AND COMMUNITY PERSONNEL TO INITIATE EFFECTIVE DISCHARGE PLANNING FOR THE ELDERLY IN ALL ISLAND HOSPITALS.

8. THAT THESE EFFORTS BE COORDINATED WITH PERSONNEL IN LONG-TERM CARE.

9. THAT THERE SHOULD BE THE DEVELOPMENT OF A CARE-GIVER SUBSIDIZATION PROGRAM THAT COULD OFFER FINANCIAL ASSISTANCE TO OFFSET THE COST OF RESPITE CARE WITHIN THE FAMILY HOME BASED ON FINANCIAL NEED.

10. THAT CONSIDERATION BE GIVEN TO THE PURCHASE OF BULK MEDICAL NURSING SUPPLIES IN ORDER TO PROVIDE SUPPLIES AT A LOWER COST TO SENIORS.

11. THAT THE RECRUITMENT OF PHYSIOTHERAPISTS SHOULD BE ACTIVELY PROMOTED AS A PROVINCIAL INITIATIVE.

12. THAT MORE EMPHASIS BE PLACED ON THE PROVISION OF PSYCHOGERIATRIC SERVICES TO THE ELDERLY IN THE COMMUNITY.

13. THAT CONSIDERATION BE GIVEN TO INCREASED FUNDING FOR HOME CARE AND SUPPORT.

14. THAT THE RESPITE CARE PROGRAM WITHIN THE DIVISION OF AGING AND EXTENDED CARE SHOULD BE MORE ACTIVELY MARKETED AMONG PROFESSIONALS AND ISLAND RESIDENTS.

15. THAT THE DIVISION OF AGING AND EXTENDED CARE COLLABORATE WITH THE DIVISION OF HOME CARE AND SUPPORT TO ENSURE THAT PRIMARY CARE GIVERS HAVE ACCESS TO THESE BEDS.

16. IF THERE ARE DEMANDS FOR VARIATIONS ON THE RESPITE PROGRAM THESE SHOULD BE MADE KNOWN TO THE PLACEMENT OFFICERS WITHIN THE DIVISION OF AGING AND EXTENDED CARE FOR CONSIDERATION OF PROGRAM OPTIONS.

17. THAT THE NEED FOR DAY PROGRAMS WITHIN THE DIVISION OF AGING AND EXTENDED CARE SHOULD BE DETERMINED BEFORE EXPANSION OCCURS.

18. THE ESTABLISHMENT OF SMALL UNITS WITHIN NURSING HOMES AND MANORS TO CARE FOR RESIDENTS WITH INCREASED MEDICAL/NURSING NEEDS SUCH AS CARE OF I.V. THERAPY, GASTRIC TUBE FEEDINGS, AND CONTINUOUS OXYGENATION. THESE UNITS SHOULD BE APPROPRIATELY FUNDED AND STAFFED.

19. A REVIEW OF THE EXISTING ACT AND REGULATIONS FOR COMMUNITY CARE FACILITIES WITH RESPECT TO SIZE OF FACILITIES.

20. THAT THERE SHOULD BE INCREASED EMPHASIS ON PREVENTIVE EDUCATION PROGRAMS WITHIN COMMUNITY CARE FACILITIES FOCUSING ON THE AREA OF NUTRITION, DRUG AWARENESS AND ACTIVATION PROGRAMS THROUGH THE UTILIZATION OF COMMUNITY NURSES, COMMUNITY OCCUPATIONAL THERAPISTS, PHYSIOTHERAPISTS, NUTRITIONISTS AND PHARMACISTS.

21. THAT THE CCF-NH BOARD SHOULD ENCOURAGE THE LICENSING OF SMALLER FACILITIES (5-10 BED) AS ONE MECHANISM TO PROMOTE AFFORDABLE CARE.

22. THAT THE PROVINCIAL GOVERNMENT SHOULD NOT PROVIDE A GENERAL SUBSIDIZATION TO COMMUNITY CARE FACILITIES BUT CONTINUE TO SUPPLEMENT LOW INCOME SENIORS THROUGH THE WELFARE ASSISTANCE PROGRAM.

23. THAT THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES REVIEW ITS PRESENT PROCESS OF SUBSIDIZATION.

24. THAT THERE MUST BE AN IMMEDIATE INCREASE IN THE SUBSIDY TO REFLECT THE INCREASING RATES WITHIN COMMUNITY CARE FACILITIES PLUS A BUILT IN MECHANISM FOR REGULAR INCREASES IN THE SUBSIDY.

25. THAT A LOGICAL SEQUENCING OF DATA SHOULD INDICATE THAT AN APPROXIMATE 100 BED EXPANSION IS NEEDED WITHIN THE NEXT DECADE. THIS COULD OCCUR IN SYSTEMATIC ADDITIONS TO THE PRESENT SYSTEM WHERE CONSISTENT PRESSURE HAS SHOWN A NEED. IT HAS BEEN THE EXPERIENCE OF THE PAST DECADE THAT AN APPROPRIATE PUBLIC AND PRIVATE MIX OF FACILITIES HAS SERVED THE POPULATION WELL AND PROMOTES A LEVEL OF COMPETITION TO PROVIDE QUALITY CARE.

26. THAT IF THERE IS EXPANSION WITHIN THE PRIVATE SECTOR THEN THE OPERATORS MUST BE SENSITIVE TO THE CHANGING NEEDS OF ISLAND ELDERLY, I.E. NEED FOR A SECURE ENVIRONMENT FOR WANDERING AND CONFUSED AND THE INCREASING MEDICAL NURSING NEEDS BASED ON ADVANCES IN MEDICAL TECHNOLOGY.

27. THAT THERE SHOULD BE IMPROVED STRATEGIES FOR THE EDUCATION OF SENIORS, CAREGIVERS AND PROFESSIONALS REGARDING THE KNOWLEDGE AND UNDERSTANDING OF THE USE OF MEDICATIONS.

28. THAT THERE SHOULD BE IMMEDIATE IMPROVEMENT IN THE MONITORING PRACTICES OF ALL HEALTH AND SOCIAL SERVICES PROFESSIONALS REGARDING MEDICATION USE IN THE ELDERLY.

29. THAT THE FOCUS OF THESE INTERVENTIONS BE TOWARD HEALTHY AGING.

30. THAT IN AN EFFORT TO PROMOTE INCREASED RESEARCH, THE P.E.I. PHARMACEUTICAL ASSOCIATION IN PARTNERSHIP WITH THE P.E.I. MEDICAL SOCIETY AND THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES BE ENCOURAGED TO SECURE A SENIORS' INDEPENDENCE GRANT FOR FUNDING OF A MAJOR STUDY TO IMPROVE THE DISPENSING, CONTROLLING AND COUNSELLING REGARDING MEDICATION USE IN THE ELDERLY.

31. AFFORDABLE, UNIVERSALLY ACCESSIBLE FOOT CARE, PROVIDED BY APPROPRIATELY TRAINED NURSES.

32. THAT THE PROVINCE, EITHER UNILATERALLY OR IN CONCERT WITH THE FEDERAL GOVERNMENT, PROVIDE FUNDING TO INTRODUCE A BASIC HOME REPAIR PROGRAM FOR LOWER INCOME SENIOR CITIZENS LIVING IN SUBSTANDARD HOUSING.

33. THAT THE PROVINCE, THROUGH THE HOUSING CORPORATION, INTRODUCE A PROGRAM TO ASSIST LOWER INCOME SENIOR CITIZENS UNDERTAKE HOME MODIFICATIONS THAT ELIMINATE BARRIERS TO INDEPENDENT LIVING.

34. THAT THE FUTURE CONSTRUCTION OF SENIOR CITIZENS HOUSING BE DIRECTED TO THOSE COMMUNITIES WHERE THERE IS EVIDENT NEED AND DEMAND.

35. THAT THE HOUSING CORPORATION, TOGETHER WITH THE DIVISION OF HOME CARE AND SUPPORT, INVESTIGATE AND DEVELOP INNOVATIVE AND COST EFFECTIVE WAYS OF PROVIDING SERVICES AND SUPPORT TO ITS ELDERLY SENIOR CITIZENS HOUSING TENANTS.

36. THAT THE P.E.I. HOUSING CORPORATION FULLY EXPLORE THE FEASIBILITY OF HOUSING OPTIONS ENDORSED BY THE CONFERENCE, POSSIBLY THROUGH THE DEVELOPMENT OF PILOT DEMONSTRATION PROJECTS.

37. THAT IN DEVELOPING INNOVATIVE HOUSING OPTIONS, THE HOUSING CORPORATION CONTINUE TO TARGET ITS ASSISTANCE TO THE MOST NEEDY SEGMENT OF THE SENIOR POPULATION (THOSE WITH THE LOWEST INCOMES AND ASSETS, HIGHEST HOUSING COSTS, WORST HOUSING CONDITIONS, ETC.).

38. THAT THE HOUSING CORPORATION INVESTIGATE WAYS OF ENCOURAGING THE PRIVATE SECTOR TO DEVELOP INNOVATIVE HOUSING ALTERNATIVES FOR THOSE SENIORS WHO HAVE THE FINANCIAL CAPABILITY OF SOLVING THEIR OWN PROBLEMS.

39. THAT AN AD HOC COMMITTEE COMPOSED OF MEMBERS FROM DIVISIONS/AGENCIES PRESENTLY INVOLVED IN ASSESSMENT OF SENIORS SHOULD BE FORMED TO DEVELOP A COMPREHENSIVE ASSESSMENT TOOL THAT COULD BE UTILIZED BY ALL PROFESSIONALS TO ASSIST IN ASSESSMENT AND PLACEMENT FUNCTIONS.

40. THE ESTABLISHMENT OF A STUDY GROUP TO DETERMINE THE MOST APPROPRIATE SINGLE POINT OF ENTRY MODEL FOR P.E.I.

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APPENDIX "A"

1. Acadian Advisory Group
2. Alzheimers Society of P.E.I.
3. Association of Nurses of P.E.I.
4. Canadian Mental Health Association, P.E.I. Division
5. Clinton View Lodge
6. Division of Home Care and Support
7. Garden Home
8. Gerontology Association of P.E.I.
9. Island Hospice Association
10. Licensed Nursing Assistants Association of P.E.I.
11. P.E.I. Advisory Council on the Status of Women
12. P.E.I. Nursing Home Association
13. P.E.I. Pharmaceutical Association
14. P.E.I. Physiotherapy Association
15. Queen Elizabeth Hospital
16. Resident Care Worker Program - Holland College
17. Sunset Lodge
18. The John M. Gillis Memorial Lodge

COMMITTEE MEMBERSHIP

Mary Campbell
P.E.I. Senior Citizens Federation

Fred Eberman
P.E.I. Housing Corporation

Leslie Jay
Community Care Facility & Nursing Home Board

Jeanette MacAulay
Hospital & Health Services Commission

Jo-Ann MacDonald
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Division of Aging & Extended Care

Gordon MacKay
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Arlene Mayme
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Dr. Douglas Meek
P.E.I. Medical Society

Susan Profit
Hospital & Health Services Commission

Peter Ramsay
Hospital Association of P.E.I.